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# It Is Not Too Late for the Health Savings Account

Jessica A. Bejerea

# IT IS NOT TOO LATE FOR THE HEALTH SAVINGS ACCOUNT

JESSICA A. BEJEREA*

## INTRODUCTION

The Health Savings Account[1] (HSA) has been heralded by both Republican members of Congress and former President George W. Bush as the solution to the rising cost of health care[2] and the swelling ranks of the uninsured.[3] In fact, since HSAs were enacted into law in 2003, former President Bush included HSA funding in his annual budget proposal each year.[4] During that same period, the HSA made appearances in more than thirty-six bills

* J.D. Candidate, Chicago-Kent College of Law, 2011; B.S., Psychology, University of Illinois at Urbana-Champaign, 1998. I would like to express my appreciation to the faculty of Chicago-Kent and the staff of the Chicago-Kent Law Review. I am particularly thankful to Professor Evelyn Brody for her help and guidance, and Ted Koshiol for his insightful edits. Finally, I am forever grateful to my friends and family, especially my husband, Florin, for their unwavering encouragement and support.

1. A Health Savings Account is a tax-advantaged savings account. Any person who qualifies as an "eligible individual" may establish and contribute money to his or her HSA. Withdrawals used to pay for the accountholder's qualified medical expenses are tax-free; deposits are deductible to the accountholder and subject to a statutory annual maximum. Eligibility requirements include enrollment in a high-deductible health plan. I.R.S. Notice 2004-2, 2004-1 C.B. 269, 270–72.

2. In 2003, the year that Health Savings Accounts were enacted into law, national health expenditures increased by approximately eight percent over the prior year and accounted for 15.8 percent of the U.S. gross domestic product. Ctr. for Medicare & Medicaid Servs., Nat'l Health Expenditure Data at tbl.1, *available at* http://www.cms.hhs.gov/NationalHealthExpendData/downloads/tables.pdf.

3. The US Census Bureau estimated that more than forty-three million people in the United States were uninsured in 2003, or fifteen percent of the total US population; the rate of the uninsured increased during the first six years of the twenty-first century. C. DeNavas-Walt, B. Proctor, & J. Smith, Income, Poverty, and Health Insurance Coverage in the United States: 2007, U.S. Census Bureau (August 2008), *available at* http://www.census.gov/prod/2008pubs/p60-235.pdf, at 20.

4. Office of Mgmt. & Budget, Exec. Office of the President, Budget of the United States Government Fiscal Year 2005, Analytical Perspectives, 248 (2005), *available at* http://www.whitehouse.gov/omb/budget/fy2005/pdf/spec.pdf; Office of Mgmt. & Budget, Exec. Office of the President, Budget of the United States Government Fiscal Year 2006, Analytical Perspectives, 283–84 (2006), *available at* http://www.whitehouse.gov/omb/budget/fy2006/pdf/spec.pdf; Office of Mgmt. & Budget, Exec. Office of the President, Budget of the United States Government Fiscal Year 2007, Analytical Perspectives, 254 (2007), *available at* http://www.whitehouse.gov/omb/budget/fy2007/pdf/spec.pdf; Office of Mgmt. & Budget, Exec. Office of the President, Budget of the United States Government Fiscal Year 2008, Analytical Perspectives, 256–57 (2008), *available at* http://www.whitehouse.gov/omb/budget/fy2008/pdf/spec.pdf; Office of Mgmt. & Budget, Exec. Office of the President, Budget of the United States Government Fiscal Year 2009, Analytical Perspectives, 254–55 (2009), *available at* http://www.whitehouse.gov/omb/budget/fy2009/pdf/spec.pdf.

proposed before Congress[5] and more than one hundred bills placed before forty-two state legislatures,[6] indicating widespread support for HSAs.

The popularity of HSAs has not been limited to politicians; HSAs have also become increasingly popular among employers and consumers. To illustrate, in January 2009, eight million people in America were enrolled in HSA-compatible high-deductible health plans,[7] 1.9 million more than had been enrolled in similar plans the year before.[8] Although recent enrollment comprises only approximately 4.5 percent of the insured private market, it is undeniable that the HSA has enjoyed an impressive adoption during its initial six years.[9]

5. *E.g.*, H.R. 3971, 111th Cong. (2009) (Health Savings Account Expansion Act of 2009); H.R. 3610, 111th Cong. (2009) (Healthy Savings and Affordability Act of 2009); H.R. 3508, 111th Cong. (2009) (Healthy Savings Act of 2009); H.R. 3478, 111th Cong. (2009) (Patient-Controlled Healthcare Protection Act of 2009); H.R. 3356, 111th Cong. (2009) (Medicare Beneficiary Freedom to Choose Act of 2009); H.R. 1763, 111th Cong. (2009) (Responsible Reinvestment Act of 2009); H.R. 1311, 111th Cong. (2009) (Unemployment Assistance Act of 2009); S. 988, 111th Cong. (2009) (SIMPLE Cafeteria Plan Act of 2009); H.R. 7166, 110th Cong. (2008) (American Health Care Access Improvement, Portability, and Cost Reduction Act of 2008); H.R. 6699, 110th Cong. (2008) (Health Security for All Americans Act of 2008); H.R. 5719, 110th Cong. (2008) (Taxpayer Assistance and Simplification Act of 2008); S. 3626, 110th Cong. (2008) (Family and Retirement Health Investment Act of 2008); S. 2547, 110th Cong. (2008) (Fair and Simple Tax Act of 2008); H.R. 3827, 110th Cong. (2007) (Active Duty Military Tax Relief Act of 2007); H.R. 2948, 110th Cong. (2007) (Increased Access to Health Insurance Act of 2007); H.R. 991, 110th Cong. (2007); H.R. 749, 110th Cong. (2007) (Health Care Choices for Seniors Act); H.R. 418, 110th Cong. (2007); H.R. 194, 110th Cong. (2007) (Prescription Drug Affordability Act); S. 1875, 110th Cong. (2007) (Healthy Tax Reform Act); S. 1556, 110th Cong. (2007) (Tax Equity for Domestic Partner and Health Plan Beneficiaries Act); S. 1019, 110th Cong. (2007) (Universal Health Care Choice and Access Act); H.R. 6134, 109th Cong. (2006) (Health Opportunity Patient Empowerment Act of 2006); H.R. 6065, 109th Cong. (2006) (Tax Free Health Savings Act of 2006); H.R. 5586, 109th Cong. (2006) (HSA Premium Affordability Act of 2006); S. 3951, 109th Cong. (2006) (Women's Retirement Security Act of 2006); S. 3585, 109th Cong. (2006) (HSA Improvement and Expansion Act of 2006); S. 3488, 109th Cong. (2006) (Tax-Free Healthcare Savings, Access, and Portability Act); S. 2585, 109th Cong. (2006) (Fallen Heroes Family Savings Act); S. 2554, 109th Cong. (2006) (Affordability in the Individual Market Act); S. 2549, 109th Cong. (2006) (Health Savings Account Affordability Act); S. 2494, 109th Cong. (2006); S. 2457, 109th Cong. (2006) (Small Business Health Insurance Relief Act of 2006); S. 2424, 109th Cong. (2006); H.R. 3075, 109th Cong. (2005) (Comprehensive Health Care Reform Act of 2005); S. 160, 109th Cong. (2005) (Save Act).

6. *See* Nat'l Conference of State Legislators, State Legislation and Actions on Health Savings Accounts (HSAs) and Consumer-Directed Health Plans, 2004-2009, http://www.ncsl.org/programs/health/hsa.htm#2007 (last visited Feb. 28, 2009) (identifying eighty-five bills concerning HSAs enacted between 2004 and 2008, and another seventy-five that did not become law).

7. According to a recent survey conducted by the American Health Insurance Plans, eight million people were covered by an HSA-compatible high deductible health plan. Approximately twenty-three percent purchased their coverage through the individual market while the remaining seventy-seven percent obtained their health plans through their employers. Am. Health Ins. Plans, January 2009 Census Shows 8.0 Million People Covered by HSA/High-Deductible Health Plans (2009), http://www.ahipresearch.org/pdfs/2009hsacensus.pdf (last accessed Nov. 10, 2009).

8. *See* Am. Health Ins. Plans, January 2008 Census Shows 6.1 Million People Covered by HSA/High-Deductible Health Plans (2008), http://www.ahipresearch.org/pdfs/2008_HSA_Census.pdf (last accessed Nov. 22, 2009).

9. According to the U.S. Census Bureau, 178.7 million Americans under age sixty-five were covered by private health insurance during 2008. U.S. Census Bureau, Health Insurance Coverage Status and

Despite this early success, the sustained growth of HSAs is threatened by recent well-intentioned but poorly devised initiatives aimed at making the accounts and their accompanying high-deductible health plans more attractive to consumers and employers. In particular, the 2006 amendments to HSA law,[10] and recent guidance issued by the Internal Revenue Service (IRS),[11] have complicated the rules for HSAs and have stopped short of clarifying at least one important but unresolved issue.

Specifically, there are three problems with current HSA law that, if not remedied, will threaten the progress that HSAs have already enjoyed and potentially discourage future enrollment. First, the rules for the qualified HSA distribution, established by the amendments to HSA law in 2006, are difficult to apply and severely penalize the unwary consumer. Congress should repeal the qualified HSA distribution. In the alternative, Congress should provide a simple alternative to the current rules and exempt from penalization those individuals who lose their eligibility status due to hardship. Second, the boon of the high-deductible health plan—immediate coverage for preventive health care—should be easier for insurers and employers to extend to consumers; either Congress or the IRS should clarify the scope of preventive care in a way that is unambiguous and reliable. Finally, IRS guidance has grown increasingly liberal with regards to high-deductible health plan design requirements. Consequently, these rules have left the door open to abuses by insurers and employers that will likely result in the circumvention of the deductible and out-of-pocket maximum requirements; the IRS should interpret HSA law addressing the underlying health plan design and eligibility conservatively, not liberally.

This note is a critique of HSA law, as it was amended by the Tax Relief and Health Care Act of 2006. The first section provides an overview of current law, including a discussion of the 2006 amendments and their effects. The second section argues that HSAs are weakened by some of the recent changes to HSA law, pursuant to the amendments and subsequent guidance, and that ambiguities surrounding the standard for preventive care have been unjustifiably neglected. The second section also considers applicable provisions from the American Health Care Access Improvement, Portability and

Type of Coverage by Selected Characteristics: 2008, Table HI01, *available at* http://www.census.gov/hhes/www/cpstables/032009/health/h01_001.htm (last visited Nov. 10, 2009).

10. Tax Relief and Health Care Act of 2006, Pub. L. No. 109-432, §§ 301-307, 120 Stat. 2922, 2948–53 (2006).

11. .During 2007 and 2008, the IRS issued guidance addressing the 2006 amendments. I.R.S. Notice 2007-22, 2007-1 C.B. 670; I.R.S. Notice 2008-51, 2008-25 I.R.B. 1163; I.R.S. Notice 2008-52, 2008-25 I.R.B. 1166.

Cost Reduction Act of 2008 and the Family and Retirement Health Investment Act of 2008, two recently proposed bills that attempt to resolve these shortcomings. Lastly, this note argues that the changes that would result from these bills are inadequate for purposes of resolving the aforementioned issues and provides alternative solutions which would strengthen HSAs and make them significantly more attractive to consumers.

## I. BACKGROUND

The HSA was born from a remarkable bill that, while historic, shares no apparent relation to the HSA or to the uninsured. The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) was a controversial bill that the media covered extensively due to its Part D provision, an innovative prescription drug benefit for Medicare beneficiaries. However, the MMA may be even more influential for its creation of the HSA, an individually owned tax-advantaged vehicle for financing personal medical expenses.[12] The HSA was originally introduced in the House of Representatives in the Health Savings and Affordability Act of 2003 (HSAA).[13] The bill was similar to various HSA legislation proposed in Congress since 1985.[14] Were it not for House Resolution 299, which appended the HSA bill to the MMA, the HSAA may have failed.[15]

In contrast to the benefits that Congress provided to Medicare recipients through the MMA, the HSA is a vehicle for individuals who do not receive Medicare benefits to exercise control over their health care expenses[16] at a time when private annual health expenditures exceed $1 trillion nationwide.[17] During a debate in the House of Representatives pursuant to the passage of House Resolution 299, the Speaker of the House, Dennis Hastert,

12. Only four months after Congress passed the MMA bill, Representative Bradley of the state of New Hampshire said in a speech to the House of Representatives, "[c]learly, much of the attention that our Nation has given to the [M]edicare drug benefit has focused on the long overdue nature of the fact that we do need a drug benefit for senior citizens on [M]edicare. . . [b]ut a little noticed section of the Medicare drug benefit legislation deals with health savings accounts." 150 Cong. Rec. H1101 (daily ed. Mar. 16, 2004).

13. H.R. 2596, 108th Cong. (2003).

14. *E.g.*, H.R. 3505, 99th Cong. (1985) (Health Care Savings Account Act of 1985). The Health Care Savings Account Act of 1985 "would [have] allow[ed] workers to establish health care savings accounts [ ] analogous to today's regular individual retirement accounts, the IRA's." 131 Cong. Rec. 26675 (Oct. 8, 1985).

15. H. Res. 299, 108th Cong. (2003).

16. I.R.S. Notice 2004-50, 2004-2 C.B. 196, 198 (Q&A 2) (explaining that mere eligibility for Medicare does not cause an individual to become HSA ineligible; however, enrollment in Medicare results in ineligibility).

17. According to a study conducted by the Centers for Medicare & Medicaid Services, the United States spent $1.2 trillion in private health expenditures during 2007, of which $775 billion was expended for private health insurance; consumer out-of-pocket expenses and other private funds accounted for the

said it best: "Earlier today we passed a health savings account bill which puts the consumer in the driver's seat in driving down costs."[18]

Congress passed the MMA on November 25, 2003, and former President George W. Bush signed the bill into law thirteen days later.[19] As a result, the HSA became the newest addition to Consumer-Driven Health Care (CDHC).[20] Similar to the other CDHC plans, the goal of the HSA and its accompanying high-deductible health plan (HDHP) is to promote a sense of consumerism and accountability amongst customers of health care.[21] CDHC generally attempts to attain this goal by enabling consumers to accumulate tax-free dollars in an account that may only be used for the health care expenses of the accountholder, her spouse, and her dependent family members.[22] Consequently, if the consumer is enrolled in a health plan that requires significant cost sharing, such as the HDHP, she is encouraged to shop wisely, opt for lower cost health care services, and obtain care only when necessary.[23] Often, the vehicles for the tax-free funds are employer sponsored, such as the health reimbursement arrangement (HRA)[24] and the flexible spending arrangement (FSA).[25] The HSA is not. It is portable. The account belongs to the individual and remains with her even if she changes jobs or becomes uninsured.[26]

other $430 billion. Ctr. for Medicare & Medicaid Servs., National Health Expenditures at tbl.3, *available at* http://www.cms.hhs.gov/NationalHealthExpendData/downloads/tables.pdf.

18. 149 Cong. Rec. H6180 (daily ed. June 26, 2003) (statement of Rep. Hastert).

19. Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Pub. L. No. 108-173, 117 Stat. 2066, 2480 (2003).

20. Consumer Driven Health Care refers to health plan designs that encourage individuals to make cost-conscious decisions about which services and procedures they use. According to the U.S. Government Accountability Office, "[a]lthough insurance carriers and employers offer several variants of CDHPs in the private health insurance market, these plans generally include three basic components—a health plan with a high deductible; an associated tax-advantaged account to pay for medical expenses under the deductible; and decision-support tools to help enrollees evaluate health care treatment options, providers, and costs." U.S. Gov't Accountability Office, Report to the Chairman, Comm. on the Budget, House of Representatives, GAO-06-514, Consumer-Directed Health Plans: Small but Growing Enrollment Fueled by Rising Cost of Health Care Coverage 7 (2006), *available at* http://www.gao.gov/new.items/d06514.pdf.

21. *Id.* at 1–2.

22. *Id.*

23. *Id.*

24. An HRA is a tax-advantaged arrangement that is funded solely by the employer, and which reimburses the employee for medical expenses that she, her spouse, and her dependents incur (as defined in § 152 and modified by § 105). Balances remaining in an HRA at the end of the year may be rolled over to the next year. I.R.S. Notice 2002-45, 2002-2 C.B. 93.

25. An FSA is a tax-advantaged arrangement that is established through a § 125 cafeteria plan; it is funded by the employee, the employer, or both. Unless there is a grace period, balances remaining in a flexible-spending arrangement at the end of the year may not be rolled over to the next year; this rule is commonly referred to as the "use-it-or-lose-it" rule. REG–142695–05, 2007-39 I.R.B. 681, 702.

26. I.R.S. Notice 2004-2, 2004-1 C.B. 269 (explaining that "an HSA is established for the benefit of an individual, is owned by that individual, and is portable").

To understand the obstacles that prevent the HSA from realizing its full potential and the solutions that aim to overcome those obstacles, it is helpful to briefly explore the HSA, the HDHP, eligibility requirements, and the basic rules governing contributions and withdrawals as established by HSA law and IRS guidance.

### *A. Eligibility*

Only an "eligible individual" may establish an HSA and make tax-free contributions to the account.[27] Section 223 of the Internal Revenue Code stipulates that, in order to be considered an HSA-eligible individual during any month, one must be covered by an HSA-compatible HDHP as of the first day of the month[28] and no other health plan except for "disregarded coverage."[29] Disregarded coverage includes permitted insurance,[30] permitted coverage,[31] and—after the 2006 amendments—coverage under an FSA during a grace period.[32] Disregarded coverage does not include Medicare benefits.[33] Medicare beneficiaries are not eligible for purposes of establishing and making contributions to an HSA.[34] Further, anyone who may be claimed as a dependent on another person's tax return is not HSA eligible.[35]

HSA law and IRS guidance limit the cost-sharing arrangements and benefit structure of an HDHP. Generally, an HSA-compatible HDHP is a health plan that has an annual deductible between $1,200 and $5,950 in 2010

27. I.R.C. § 223(a) (CCH 2009).

28. Generally, any health plan with a high deductible is considered an HDHP; however, an HDHP is only considered HSA compatible if it conforms to the minimum deductible and out-of-pocket limits required under Code section 223. I.R.C. § 223(c)(1)(A)(i).

29. I.R.C. § 223(c)(1)(B); Rev. Rul. 2004-38, 2004-1 I.R.B. 717 ("Under section 223, an eligible individual cannot be covered by a health plan that is not an HDHP unless that health plan provides coverage for permitted insurance or permitted coverage.").

30. I.R.C. § 223(c)(1)(B)(i). Permitted insurance is defined as (1) insurance if substantially all of the coverage provided under such insurance relates to (a) liabilities incurred under worker's compensation law, (b) tort liabilities, (c) liabilities relating to ownership or use of property (e.g., auto insurance), or (d) such other similar liabilities as the Secretary may prescribe by regulations; (2) insurance for a specified disease or illness; and (3) insurance that provides a fixed payment for hospitalization. I.R.C. § 223(c)(3).

31. I.R.C. § 223(c)(1)(B)(ii). Permitted coverage is coverage (whether provided through insurance or otherwise) for accidents, disability, dental care, vision care, or long-term care. Id.

32. I.R.C. § 223(c)(1)(B)(iii). Coverage under an FSA during a grace period is disregarded if the balance at the end of such plan year is zero or the beneficiary is making a qualified HSA distribution at the end of the plan year that results in the depletion of the remaining FSA balance.

33. I.R.C. § 223(c)(1)(B).

34. I.R.C. § 223(b)(7).

35. I.R.C. § 223(b)(6). Therefore, a child cannot have an HSA of his or her own. However, a child's parent who is an HSA-eligible individual may have an HSA and use the money in the account to pay for the child's medical expenses.

for self-only coverage and between $2,400 and $11,900 for family coverage.[36] The plan must limit the amount that the insured pays each year for medical expenses that the HDHP covers, inclusive of the deductible.[37] This limit (the "out-of-pocket maximum") in 2010 for self-only coverage must not exceed $5,950 and, in the case of family coverage, $11,900.[38] The annual minimum deductible and the out-of-pocket maximum are indexed for inflation.[39] Further, a health plan is not considered an HSA-compatible HDHP if it does not offer "significant benefits."[40] For example, hospital-only health plans and health plans offering only disregarded coverage are not considered HSA compatible.[41]

Furthermore, to qualify as an HSA-compatible health plan, all the benefits that the HDHP covers must be subject to the deductible except preventive care.[42] Since 2004, the IRS has issued extensive guidance explaining the rules pertaining to the HDHP deductible and the out-of-pocket maximum.[43] Included within the guidance, for example, is clarification that an HSA-compatible family HDHP may be designed to include an embedded deductible—an individual deductible for each person that a family HDHP covers—as long as it is equal to or greater than the statutory minimum deductible for family coverage.[44] The IRS also permits an HDHP, for purposes of satisfying the plan's deductible, to cover a period of time that is longer than twelve months even though the statutory minimum annual deductible assumes a twelve-month plan year; however, according to the IRS, the deductible must be increased to accommodate the longer year.[45] Thus, if the deductible is

36. I.R.C. § 223(c)(2)(A)(i); Rev. Proc. 2009-29, 2009-22 I.R.B. 1050 (announcing the 2010 cost of living adjustments).

37. I.R.C. § 223(c)(2)(A)(ii). An HDHP does not need to expressly limit the plan's out-of-pocket expenses if it is unnecessary to do so to prevent the insured from exceeding the statutory maximum for out-pocket expenses. I.R.S. Notice 2004-50, 2004-2 C.B. 196, 200 (Q&A 17).

38. Rev. Proc. 2009-29, 2009-22 I.R.B. 1050.

39. I.R.C. § 223(g).

40. I.R.S. Notice 2008-59, 2008-29 I.R.B. 123, 127 (Q&A 14 clarifies that "[a] plan must provide significant benefits to be an HDHP").

41. I.R.C. § 223(c)(1)(B); I.R.S. Notice 2008-59, 2008-29 I.R.B. 123, 127 (Q&A 14).

42. I.R.C. § 223(c)(2)(C); I.R.S. Notice 2004-2, 2004-1 C.B. 269 (explaining that, except for preventive care, a plan may not provide benefits for any year until the deductible for that year is met).

43. I.R.S. Notice 2004-2, 2004-1 C.B. 269, 269–70; I.R.S. Notice 2004-50, 2004-2 C.B. 196, 199–201; I.R.S. Notice 2008-59, 2008-29 I.R.B. 123, 126–27.

44. I.R.S. Notice 2004-2, 2004-1 C.B. 269 (Q&A 3); I.R.S. Notice 2008-59, 2008-29 I.R.B. 123, 125 (Q&A 4(a)). A plan is an HDHP only if, without regard to which family member or members incur expenses, no amounts are payable from the HDHP until the family has incurred annual covered medical expenses in excess of the minimum annual deductible. An embedded deductible allows the insurer to design an HDHP with a family deductible substantially higher than the statutory minimum, while providing coverage to any individual within the family who satisfies a lesser deductible.

45. The IRS issued guidance in 2004 that provided a formula to test whether an HDHP with a plan year longer than twelve months complies with Code section 223. According to the formula, the minimum deductible for an HDHP that is longer than twelve months is calculated by first multiplying the statutory

high enough, an HDHP may permit "fourth quarter carry-over," which is the practice of carrying over medical expenses incurred during the last three months of a plan year to the next year for purposes of offsetting the new deductible.

An important principle that the IRS conveys throughout its guidance addressing HSAs is that nothing may interfere with the HSA-eligible individual's burden to pay the statutory minimum deductible for non-preventive health care each year.[46] Consequently, anyone covered by a major health plan that is not an HDHP, including those enrolled in non-HDHP spousal coverage,[47] Medicare beneficiaries,[48] individuals enrolled in TRICARE,[49] and recipients of medical benefits through the Department of Veteran's Affairs,[50] are not eligible individuals. Moreover, an eligible individual's employer may not reimburse, directly or indirectly, any non-preventive medical expenses prior to the statutory minimum deductible, lest the employee lose her eligibility status.[51] For example, an eligible individual may not receive coverage from her employer through a general health HRA or FSA.[52] An employee may not even receive free care or low-cost care from an employer's on-site clinic unless the benefits offered through the clinic are "insignificant."[53]

Despite these stringent rules, the IRS permits a number of HSA-compatible arrangements that provide creative alternatives to the otherwise-

minimum deductible for that year by the number of months within the extended plan year, which is then divided by twelve months. I.R.S. Notice 2004-50, 2004-2 C.B. 196, 200–01 (Q&A 24). The number that results is the minimum deductible for the longer plan year.

46. *E.g.*, I.R.S. Notice 2004-50, 2004-2 C.B. 196, 198; I.R.S. Notice 2008-59, 2008-29 I.R.B. 123, 125–26.

47. I.R.S. Notice 2004-2, 2004-1 C.B. 269, 270 (Q&A 5).

48. I.R.S. Notice 2004-50, 2004-2 C.B. 196, 198 (Q&A 4).

49. I.R.S. Notice 2004-50, 2004-2 C.B. 196, 198 (Q&A 6).

50. However, VA benefits do not result in loss of eligibility if the individual is merely eligible for but has not received any such benefits in the preceding three months. I.R.S. Notice 2004-50, 2004-2 C.B. 196, 198 (Q&A 5). The IRS later recognized an exception to this rule in cases where the VA benefits "consist solely of disregarded coverage or preventive care." I.R.S. Notice 2008-59, 2008-29 I.R.B. 123, 126 (Q&A 9). Legislation proposed in the Senate and the House of Representatives during 2008 and 2009 would expand this exception to include certain "periodic hospital care or medical services." *E.g.*, H.R. 3508, 111th Cong. § 4 (2009); H.R. 2974, 111th Cong. (2009); S. 3626, 110th Cong. § 4 (2008).

51. I.R.S. Notice 2008-59, 2008-29 I.R.B. 123, 125 (Q&A 3). However, the employer may reimburse the employee for expenses falling under the category of disregarded coverage. *Id.*

52. I.R.S. Rev. Rul. 2004-45, 2004-1 C.B. 971, 972 ("[A]n individual who is covered by an HDHP and a health FSA or HRA that pays or reimburses section 213(d) medical expenses is generally not an eligible individual for the purpose of making contributions to an HSA."). Accordingly, an individual is not HSA eligible if his spouse's HRA or FSA can reimburse his medical expenses.

53. I.R.S. Notice 2008-59, 2008-29 I.R.B. 123, 126 (Q&A 10).

incompatible general health HRA and FSA.[54] For example, an employer may limit the types of employee medical expenses that the employer reimburses through the HRA or FSA to expenses falling under the category of "disregarded coverage."[55] This type of an arrangement, the "limited-purpose" HRA or FSA, exclusively covers expenses for vision, dental or preventive care.[56] Alternatively, the employer may offer a "post-deductible" HRA or FSA, which postpones reimbursements of employee medical expenses until the employee satisfies her HDHP deductible.[57] Thus, the post-deductible arrangement helps the HSA-eligible employee pay for any later coinsurance expenses.[58] A "retirement" HRA or FSA, which suspends reimbursement until the employee retires, is also compatible with the HSA and permits an employee to remain an eligible individual until she retires.[59]

In addition to guidance concerning the rules surrounding the HDHP deductible and impermissible concurrent coverage, the IRS has also addressed the types of expenses that must apply to the out-of-pocket maximum. Generally, the out-of-pocket maximum includes the health plan's deductible, including embedded deductibles; coinsurance; and co-payments.[60] However, the out-of-pocket maximum does not include the premium that the insured pays for the HDHP[61] or penalties that the insured incurs for any failure to obtain pre-certification for particular providers or services,[62] even if the penalty takes the form of additional coinsurance.[63] Both the minimum deductible and the out-of-pocket maximum do not take into account the insured's medical expenses for services that the HDHP does not cover, such as amounts for benefits that cease to be covered because the insured exceeds

54. I.R.S. Rev. Rul. 2004-45, 2004-1 C.B. 971, 972 ("However, an individual is an eligible individual for the purpose of making contributions to an HSA for periods the individual is covered under the following arrangements.").

55. *Id.*

56. *Id.*

57. *Id.* Post-deductible HRAs and FSAs may begin paying employee medical expenses once the statutory minimum HDHP deductible is met, even if the employee's deductible is higher than the annual minimum required under Code section 223. Accordingly, a post-deductible arrangement may begin paying the medical expenses of a person who has met an embedded deductible. I.R.S. Notice 2008-59, 2008-29 I.R.B. 123, 125 (Q&A 4(b)).

58. While an HDHP may have a deductible as high as $5,950 for self-only coverage and $11,900 for family coverage, the corresponding maximum annual HSA contribution for 2010 is only $3,050 and $6,150 respectively. Legislation in the House of Representatives would increase the statutory annual maximum for HSA contributions to the HDHP annual out-of-pocket maximum. H.R. 3610, 111th Cong. § 4 (2009).

59. I.R.S. Rev. Rul. 2004-45, 2004-1 C.B. 971, 972–73.

60. I.R.S. Notice 2004-50, 2004-2 C.B. 196, 200.

61. *Id.*

62. *Id.* (Q&A 18).

63. *Id.* (Q&A 19).

the annual and lifetime limits for such benefits.[64] Accordingly, for the purpose of the statutory minimum deductible and the out-of-pocket maximum, only the medical expenses that the HDHP covers matter.[65]

### *B. The Health Savings Account*

The HSA is an individually owned savings account that an eligible person may establish through a bank, an insurance company, or any IRS approved Individual Retirement Account (IRA) or Medical Savings Account (MSA)[66] trustee or custodian.[67] Accordingly, a health insurance company may administer both an individual's HSA and HDHP.

More specifically, HSAs are portable, tax-advantaged accounts that eligible individuals may establish solely for the purpose of financing the medical expenses that they and their families incur.[68] The law imposes an annual limit on the amount that may be contributed to an account.[69] The maximum contribution, like the HDHP deductible and out-of-pocket maximum, is indexed for inflation.[70] Originally, HSA law permitted each eligible individual to annually contribute up to the lesser of the individual's HDHP deductible and the statutory maximum. Pursuant to the 2006 amendments, all accountholders may contribute up to the statutory maximum, notwithstanding their deductibles.[71] In 2010, an accountholder with self-only HDHP coverage may contribute up to $3,050 and $6,150 for family coverage.[72] In an

64. *Id.* (Q&A 21). An HDHP may impose lifetime and annual limits on specific benefits. Amounts paid by an individual above a lifetime limit do not count toward the annual out-of-pocket maximum. Such limitations must be reasonable and, accordingly, may not function in such a way as to deprive the insured of significant health care benefits. *Id.* at 199 (Q&A 15). Also, lifetime or annual limitations on specific benefits are not reasonable if they result in the circumvention of the plan's out-of-pocket maximum. *Id.*

65. *Id.* As a result, if an HDHP's deductible includes the insured's expenses for medical services that the HDHP does not cover, the HDHP may not consider such expenses when determining whether the insured has met the statutory minimum deductible.

66. I.R.C. § 220 (CCH 2009). The MSA is the predecessor to the HSA.

67. I.R.S. Notice 2004-2, 2004-1 C.B. 269, 270 (Q&A 9). In addition, "[o]ther persons may request approval to be a trustee or custodian in accordance with the procedures set forth in Treas. Reg. [section] 1.408-2(e)." *Id.*

68. I.R.C. §§ 223(d)(1) & (2)(a) (CCH 2009).

69. I.R.C. § 223(b).

70. I.R.C. § 223(g). The annual maximum for family coverage was equal to twice the dollar amount for self-only coverage when the MMA was enacted. I.R.C. § 223(b)(2). However, according to I.R.C. § 223(g)(2), the annual maximum contribution will be rounded to the nearest multiple of $50 in cases where the annual increase is not a multiple of $50. I.R.C. § 223(g)(2).

71. Tax Relief and Health Care Act of 2006, Pub. L. No. 109-432, § 303, 120 Stat. 2922, 2949–50.

72. Rev. Proc. 2009-29, 2009-22 I.R.B. 1050 (announcing the 2010 cost of living adjustments).

effort to encourage accountholders to save toward their post-retirement medical expenses,[73] Congress allowed accountholders fifty-five years old and older to make additional contributions, or "catch-up contributions," to their HSAs.[74]

Generally, all contributions to HSAs must be in cash.[75] Further, contributions are not limited to those that the accountholder makes: anyone may fund another person's account, including an employer and family members.[76] The accountholder may exclude after-tax contributions that she or anyone else makes to her HSA from her adjusted gross income, up to the statutory annual maximum.[77] Similar to the IRA, HSA funds may be invested in bank accounts, annuities, certificates of deposit, stocks, mutual funds, or bonds;[78] earnings are tax-free.[79]

Also like an IRA, an HSA can only be owned by one person.[80] Therefore, while a married couple may share the same HDHP, they may not share ownership in the same HSA.[81] However, spouses who are both eligible individuals covered by one or more family HDHP may establish separate accounts and apportion the maximum family contribution between the accounts; in this situation, spouses may not separately contribute the family maximum to their accounts.[82] Because, prior to 2007, HSA law limited annual HSA contributions to the lesser of the accountholder's HDHP's deductible and the statutory annual maximum, a married couple in the situation described above was permitted to contribute to the multiple accounts no more than the lesser of the statutory maximum for family coverage and the value of the lesser of the spouses' HDHP deductibles.[83]

Even though the maximum HSA contribution is expressed as an annual limitation, contributions are determined on a monthly basis.[84] Generally, for

73. *See* 150 Cong. Rec. H1101 (Mar. 16, 2004) (statement of Rep. Bradley) ("[I]f you are in the age group of 55 to 65, you can do catch-up contributions of up to $1,000 more because retirement is coming along fairly quickly.").

74. I.R.C. § 223(b)(3). The maximum catch-up contribution for 2010 is $1,000. I.R.C. § 223(b)(3)(B).

75. I.R.C. § 223(d)(1)(A)(i).

76. I.R.S. Notice 2004-50, 2004-2 C.B. 196, 201 ("Although Q&A 11 of Notice 2004-2 only refers to contributions by employers or family members, any person (an employer, a family member or any other person) may make contributions to an HSA on behalf of an eligible individual.").

77. I.R.C. §§ 223(a)–(b).

78. I.R.S. Notice 2004-50, 2004-2 C.B. 196, 206 (Q&A 65).

79. I.R.S. Notice 2004-2, 2004-1 C.B. 269, 271 (Q&A 20).

80. I.R.S. Notice 2004-50, 2004-2 C.B. 196, 206 (Q&A 63).

81. *Id.*

82. I.R.S. Notice 2004-2, 2004-1 C.B. 269, 271 (Q&A 15).

83. *Id.*

84. I.R.C. § 223(b)(1) (CCH 2009).

each month that an accountholder is an eligible individual, she may contribute up to one-twelfth of the annual maximum to her HSA.[85] Consequently, an accountholder who is eligible during fewer than twelve months during a year generally may not contribute the full annual contribution for her coverage type.[86] While eligibility is determined on a monthly basis, HSA law does not require that the accountholder make contributions to her HSA only after she earns the amounts, month by month; the accountholder is only required to deposit all contributions for the year no later than the deadline for her federal tax return.[87] Accordingly, the accountholder has the flexibility to deposit up to the annual maximum as early as the first day of the year. By doing so, she gains the benefit of having the funds available to her to afford significant but early incurred medical expenses; moreover, she gains the benefit of earning interest on the full annual amount throughout the year if she does not need the funds or chooses to save them rather than use them.

However, this approach is problematic for the accountholder who loses her eligibility any time during the year, albeit unintentionally. Since the annual maximum is prorated, contributions that are made early, but not yet earned, will be considered "excess contributions" if the accountholder fails to earn them before the end of the year.[88] For example, an accountholder who is covered by an employer-sponsored HDHP might become HSA ineligible if the employer terminates her employment that year. While she may have the option to keep her health coverage through COBRA, the cost of doing so may prove too burdensome.[89] Furthermore, she might have trouble buying coverage in the individual market due to a pre-existing condition or, if she is able to procure coverage, it may be too expensive.[90] The accountholder can remediate the problem by withdrawing the excess contribution, along with any associated earnings or interest, before the day that her

85. *Id.*

86. The 2006 amendments allow a person in this situation to contribute the full annual maximum contribution even though she was eligible for fewer than twelve months. However, she is required to remain an eligible individual during a thirteen-month testing period. I.R.C. § 223(b)(8).

87. I.R.S. Notice 2004-2, 2004-1 C.B. 269, 271 (explaining that contributions must be deposited no later than the due date of the accountholder's federal tax return).

88. *See* I.R.C. § 223(f)(3)(B).

89. *See* Karyn Schwartz, Kaiser Comm'n on Pol'y Brief and the Uninsured, Health Coverage in a Period of Rising Unemployment (2008), http://www.kff.org/uninsured/upload/7842.pdf.

90. Approximately fifteen percent of adults under age sixty-five who apply for health insurance in the individual market who are subject to underwriting are declined coverage; approximately twenty-eight percent of those individuals who are offered coverage are required to either pay a higher premium, waive coverage for certain health conditions, or both. Thomas F. Wildsmith, Ctr. for Pol'y & Research, Am Health Ins. Plans, Individual Health Insurance: A Comprehensive Survey of Affordability, Access, and Benefits 10-11 tbls. 6–7 (2005), http://www.ahipresearch.org/pdfs/individual_insurance_survey_report8-26-2005.pdf.

federal tax return is due for that year.[91] She must also include in her income for that tax year the amounts that she withdraws from her HSA.[92] If she waits too long to make the withdrawal, she incurs a 6 percent excise tax for each year that she is delinquent.[93]

Once deposits are made to an HSA they may remain in the account regardless of whether the accountholder remains an eligible individual. While eligibility is vital to an individual's ability to make contributions to her HSA, the accountholder need not remain eligible to keep the funds that she previously deposited in her account, nor need she remain eligible to use the funds tax-free.[94] Accordingly, the rules for the distribution of account funds differ considerably from the rules regulating contributions to an HSA. The rules for the former, stated simply, require that, to be tax-free, the accountholder must use the withdrawn funds from her HSA solely for the reimbursement of her unreimbursed qualified medical expenses.[95]

Qualified medical expenses are medical expenses, as defined in the Internal Revenue Code under section 213(d), which an individual, her spouse, or tax dependents incur.[96] The principle role of Code section 213 is to provide taxpayers with the ability to take a deduction for the cost of their and their 'families' unreimbursed medical care during the tax year in excess of 7.5 percent of the taxpayer's gross income.[97] With the advent of CDHC, Code section 213(d) also became the foundation for the laws that regulate health reimbursement arrangements,[98] flexible spending arrangements,[99] medical savings accounts,[100] and, in 2003, health savings accounts.[101]

Specifically, Code section 213(d) medical expenses are expenses "for the diagnosis, cure, mitigation, treatment, or prevention of [a] disease, or for

91. I.R.C. § 223(f)(3)(A).

92. *Id.*

93. I.R.C. § 4973(a)(5) (CCH 2009).

94. I.R.S. Notice 2004-2, 2004-1 C.B. 269, 272 (Q&A 25) ("Distributions from an HSA used exclusively to pay for qualified medical expenses of the account beneficiary, his or her spouse, or dependents are excludable from gross income. In general, amounts in an HSA can be used for qualified medical expenses and will be excludable from gross income even if the individual is not currently eligible for contributions to the HSA.").

95. I.R.C. §§ 223(f)(1)–(2).

96. I.R.C. § 223(d)(2)(A).

97. Expenses paid and not compensated for by insurance or otherwise for the medical care of the taxpayer, his spouse, or a dependent are deductible to the extent that such expenses exceed 7.5 percent of adjusted gross income. I.R.C. § 213(a) (CCH 2009).

98. I.R.C. § 105(b) (CCH 2009).

99. *Id.*

100. I.R.C. §§ 220(d)(1)–(2) (CCH 2009).

101. I.R.C. §§ 223(d)(1)–(2).

the purpose of affecting any structure or function of the body, [and] for transportation primarily for and essential to [such medical care]."[102] For example, the services covered by a health insurance policy are generally qualified medical expenses.[103] These amounts are the expenses that a health insurer pays to doctors, hospitals and other health care providers for the medical services that they provide to the insured.[104] Consequently, the share of those expenses that the insured is expected to pay out-of-pocket are also qualified medical expenses. The insured encounters out-of-pocket expenses when she pays co-pays, coinsurance, or a deductible. However, health insurance generally does not cover all qualified medical expenses. In addition to out-of-pocket expenses, the insured must finance her uncovered health care. For example, a health plan might exclude maternity care from the services that it covers; accordingly, if the insured incurs medical expenses for maternity related services, in this example, she must pay for those expenses without the help of the insurer. These too are qualified medical expenses.[105]

An HSA accountholder may elect to use the funds in her HSA for any of the aforementioned types of qualified medical expenses, all exempt from federal income tax and often exempt from state tax.[106] However, there are certain types of qualified medical expenses that HSA law expressly excludes: an accountholder may not use HSA funds to pay for health insurance[107] unless the coverage is for COBRA continuation coverage,[108] long-

102. I.R.C. §§ 213(d)(1)(A)–(B). IRS publication 502 provides an incomplete list of expenses that qualify as medical expenses and another list of expenses that do not qualify as section 213 medical expenses. I.R.S. Pub. No. 502, at 5–17 (2008).

103. *See* Treas. Reg. § 1.213-1(e) (2009).

104. *Id.*

105. *Id.*

106. Code section 223(a) allows the HSA accountholder to take a deduction, for the taxable year, for contributions made on the accountholder's behalf to his or her HSA. However, any amount paid from a health savings account that is not used exclusively to pay the qualified medical expenses of the account beneficiary shall be included in the gross income of such beneficiary. I.R.C. §§ 223(f)(1)–(2). For an analysis of states that have conformed to the IRC for HSA purposes, *see* Nat'l Conference of State Legislators, State Legislation and Actions on Health Savings Accounts (HSAs) and Consumer-Directed Health Plans, 2004-2009, http://www.ncsl.org/programs/health/hsa.htm#2007 (last visited Feb. 28, 2009).

107. I.R.C. § 223(d)(2)(B) (CCH 2009).

108. I.R.C. § 223(d)(2)(C)(i). COBRA is an acronym for the Consolidated Omnibus Budget Reconciliation Act. Congress passed COBRA health benefit provisions in 1986. According to the Department of Labor, "[t]he law amends the Employee Retirement Income Security Act, the Internal Revenue Code and the Public Health Service Act to provide continuation of group health coverage that otherwise might be terminated." *See* U.S. Dep't of Labor, FAQs For Employees About COBRA Continuation Health Coverage, http://www.dol.gov/ebsa/faqs/faq_consumer_cobra.HTML (last visited Nov. 12, 2009).

term care insurance,[109] coverage during a period in which the individual receives unemployment compensation under any federal or state law,[110] or Medicare premiums.[111] As a result, an accountholder may not pay for her HDHP premiums from her HSA.[112]

### *C. The HSA after 2006*

Congress amended HSA law in 2006 by enacting the Health Opportunity Patient Empowerment Act of 2006 (HOPE), Title III of the Tax Relief and Health Care Act of 2006.[113] The amendments aimed to encourage new enrollment in HDHPs and HSAs by making them more attractive[114] and addressing certain "obstacles to the use of HSAs."[115] Also cited as a reason for the amendments was the importance of lowering the increasing number of uninsured;[116] specifically, HDHP coverage is less expensive than other, more traditional forms of health insurance.[117] Thus, some uninsured who are unable to afford other forms of health insurance might be able to afford an HDHP.

Congress's attempt to make HSAs more attractive relied upon five significant modifications to HSA law. First, the amendments sought to facilitate employees' transition from the other CDHC plans that their employers offer

109. I.R.C. § 223(d)(2)(C)(ii). Subject to the annual limitations established by I.R.C. section 7702B(b).

110. I.R.C. § 223(d)(2)(C)(iii).

111. I.R.C. § 223(d)(2)(C)(iv).

112. However, legislation has been and continues to be proposed in both houses of Congress that would permit HSAs to reimburse accountholders for their HDHP premiums. *E.g.*, S. 3626, 110th Cong. § 7(a) (2008) (Family and Retirement Health Investment Act of 2008); S. 46, 110th Cong. § 2 (2007) (Affordability in the Individual Market Act); H.R. 5586, 109th Cong. § 2 (2006) (HSA Premium Affordability Act of 2006).

113. Tax Relief and Health Care Act of 2006, Pub. L. No. 109-432, §§ 302–07, 120 Stat. 2922, 2948–53.

114. H.R. Rep. No. 109–704, at 6 (2006).

115. *Id.* at 11 ("Despite this growth, the early experience with HSAs has revealed a number of features of present law that the Committee believes create obstacles to the use of HSAs. The Committee bill includes provisions to address these obstacles.").

116. *Id.* at 6 ("Millions of Americans have no health insurance coverage. Covering America's uninsured is a top priority for the Congress. High deductible health plans provide an opportunity for many uninsured individuals to afford health insurance.").

117. 152 Cong. Rec. S722 (Feb. 6, 2006) (statement of Sen. Hatch: "Health savings accounts are a good thing for our citizens, and they are a good thing for the economy. HSAs will make health insurance less expensive in the long run, which is the best thing we can do to tackle the problem of the uninsured in this country."). Recently, a three year study revealed that employer-provided HSA compatible HDHPs cost approximately $782–$2,559 less annually than the average employer-provided health plan in 2008. Am. Health Ins. Plans, Health Savings Accounts & Account-Based Health Plans: An Overview of Research 7 (2009), http://www.ahip.org/content/default.aspx?docid=25947.

to HSA-compatible HDHPs.[118] Specifically, the amendments permitted a "qualified HSA distribution," a one-time, tax-free balance transfer from an employee's HRA or FSA to a newly established HSA.[119] Furthermore, the amendments exempted the qualified HSA distribution from the annual maximum HSA contribution, thus allowing the employee to contribute both the annual maximum and the qualified HSA distribution to her HSA within the same year.[120] The tax advantage of the distribution, though, was made contingent upon a thirteen-month "testing period," starting the month of the transfer and during which the accountholder must remain an HSA-eligible individual.[121]

Second, the amendments allow anyone who becomes HSA eligible "mid-year" to establish an HSA and contribute the full annual maximum contribution.[122] Individuals who are HSA eligible for fewer than twelve months in a year may make the full annual HSA contribution for that year as long as they are eligible individuals during the last month of the tax year.[123] Congress recognized the problem that these individuals faced: someone who enrolls in an HDHP during the year "may have exposure for the full deductible under the plan, whereas the permitted contribution to the HSA is limited by the number of months the individual was in the plan."[124] To illustrate, someone who becomes HSA eligible on the first day of November may incur medical expenses in excess of the HDHP's deductible during November and December. However, prior to the amendments, HSA law only allowed the person to make HSA contributions for those two months that she was an eligible individual, two-twelfths of the annual maximum. To prevent potential abuse, Congress included a "testing period" during which the individual must remain HSA eligible, beginning December of the first year and ending in December of the next year.[125]

Third, the amendments revoked the "lesser-of rule," which limited the HSA-eligible accountholder's contributions each year to the value of his

118. .H.R. Rep. No. 109–704, at 12 ("The provision is designed to assist individuals in transferring from another type of health plan to a high deductible health plan.").

119. Tax Relief and Health Care Act of 2006, Pub. L. No. 109-432, § 302, 120 Stat. 2922, 2948–49.

120. I.R.S. Notice 2007-22, 2007-1 C.B. 670 ("Qualified HSA distributions are not taken into account in applying the annual limit for HSA contributions.")

121. § 302, 120 Stat. at 2948–49 ("The term 'testing period' means the period beginning with the month in which the qualified HSA distribution is contributed to the health savings account and ending on the last day of the 12th month following such month.").

122. § 305, 120 Stat. at 2950–51.

123. *Id.*

124. H.R. Rep. No. 109–704, at 11.

125. § 305, 120 Stat. at 2950–51; H.R. Rep. No. 109–704, at 11 ("To prevent abuse of this increased contribution, the individual must remain in a high deductible plan for [twelve] months.").

HDHP's deductible, but not more than the statutory established limit.[126] The amendments, by revoking this rule, enabled all HSA-eligible accountholders to contribute up to the statutory annual maximum contribution. Accordingly, an accountholder whose deductible is less than the statutory maximum can deposit money in her HSA for post-deductible expenses, such as coinsurance or co-payments, and even medical expenses not covered by the HDHP.

Fourth, the amendments permit all HSA-eligible accountholders to roll over amounts from 'their Individual Retirement Accounts (IRA) to their HSAs.[127] Unlike the qualified HSA distribution, Congress required that the IRA balance transfer count toward the HSA annual maximum contribution limits.[128] Finally, the amendments require the IRS to publish the annual adjustments to the HSA contribution maximum, the HDHP minimum deductible, and the HDHP out-of-pocket limit by June of the preceding calendar year.[129] This modification "allow[s] individuals, insurers, and employers to know in advance of a year what plans will qualify an individual for an HSA."[130]

## II. ANALYSIS

The 2006 amendments to HSA law and recent guidance issued by the IRS have complicated the rules for HSAs and failed to clarify the scope of preventive care. Congress should repeal the troubled qualified HSA distribution and amend HSA law to permit eligible individuals to temporarily keep their HRAs and FSAs. Furthermore, Congress and the IRS should defer to nationally established guidelines for the purpose of clarifying the meaning of preventive care, such as those standards provided by the U.S. Preventive Task Force or the American Medical Association's CPT codes. Finally, recent guidance issued by the IRS has complicated the requirements for HDHPs; the IRS should simplify HDHP plan design requirements by modifying Notice 2008-59 in closer accordance with Code section 223.

126. § 303, 120 Stat. at 2949–50.

127. § 307, 120 Stat. at 2951–53.

128. *Id.* at 2953.

129. § 304, 120 Stat. at 2950. In the years preceding the amendments, annual inflation adjustments for HSAs were published in November or December. *See*, *e.g.*, Rev. Proc. 2004-71, 2004-50 I.R.B. 970, 975; Rev. Proc. 2005-70, 2005-47 I.R.B. 979, 984; Rev. Proc. 2006-53, 2006-48 I.R.B. 996, 1002.

130. H.R. Rep. No. 109–704, at 12.

### *A. Congress Should Repeal the Qualified HSA Distribution.*

Congress amended HSA law in 2006 primarily to increase the popularity of HSAs. Senator Hatch introduced the amendments in June 2006, proclaiming: "My proposal aims to make HSAs more attractive to employees, more attractive to employers, and more attractive to older workers."[131] The qualified HSA distribution ("qualified distribution"), a tax-free balance transfer from an FSA or HRA ("arrangement") to an HSA, supports this purpose by encouraging employees enrolled in other CDHC plans to transition to HSAs. The qualified distribution is generally available to any person who had an arrangement during the year in which Congress passed the amendments.[132] However, funds may only be transferred from the individual's arrangement to an HSA that she establishes and only if the employer who sponsors the arrangement offers the distribution.[133]

The qualified distribution is additionally subject to many other requirements enumerated in the amendments and expanded upon by IRS guidance in Notice 2007-22.[134] Critics quickly complained that the resulting rules were unnecessarily complex. These criticisms were accompanied by proposed solutions that envisioned changing the Service's guidance to accommodate public concerns. While the IRS did not modify Notice 2007-22 to incorporate any of the proposed solutions, Congress has attempted to resolve the problems through two distinct proposed bills, one in the House and the other in the Senate. Both bills would once again amend HSA law. Neither goes far enough. Congress should instead repeal the qualified HSA distribution and temporarily allow new HSA accountholders to keep their HRAs and FSAs.

#### 1. "Unnecessarily Complex" Rules

The HSA amendments allow employers to offer their employees a qualified distribution any time before 2012 but not after.[135] The employee may only elect one qualified distribution from each arrangement.[136] Congress further limited the distribution to the lesser of the balance in the employee's arrangement on September 21, 2006, and the date that the employer transfers the funds from the employee's arrangement to the HSA,[137] as determined on

131. 152 Cong. Rec. S6581 (June 27, 2006) (statement of Sen. Hatch).
132. I.R.C. § 106(e)(2)(A) (CCH 2009).
133. I.R.S. Notice 2007-22, 2007-1 C.B. 670, 671–72.
134. *Id.* at 670.
135. I.R.C. § 106(e)(2)(B).
136. *Id.*
137. I.R.C. § 106(e)(2)(A).

a cash basis.[138] Consequently, in order to obtain a distribution, the employee must have been enrolled in an arrangement on September 21, 2006.[139] If an arrangement covered an employee on September 21, 2006, but the employee subsequently changed employers, thereby ending her HRA or FSA coverage with the first employer and beginning new coverage under the second employer, the employee may not make a qualified distribution since neither the first nor the second arrangement existed on both dates, September 21, 2006, and the date that the qualified distribution is executed.[140] In addition, as a consequence of the "lesser of" balance rule, if the arrangement has been depleted and the balance is zero at either point in time, no amount may be rolled over to the HSA since the lesser amount is zero.

While the qualified distribution does not count towards the employee's annual maximum contribution,[141] there are many complex, time-sensitive administrative rules that the employer must adhere to in order for the distribution to be tax-free.[142] Generally, the employer must modify the HRA or FSA by amending the arrangement's written plan to allow for the qualified distribution, the employee must expressly elect the balance transfer, the employer must freeze the arrangement's balance at the end of the plan year and complete the transfer within two and a half months thereafter, and the qualified distribution must completely deplete the arrangement of its remaining funds.[143] At the heart of this complexity is the absolute rule of the "eligible individual." Only eligible individuals may have an HSA and contribute to their accounts tax-free, including those contributions made in the form of a qualified distribution.[144] By definition, an eligible individual may not have conflicting coverage such as a general health HRA or FSA; the eligible individual may only have one or more HDHPs and permitted coverage or insurance.[145]

Thus, timing is crucial for the qualified distribution since the employee must transition from being an ineligible individual to an HSA-eligible individual. The IRS has taken the position that the employee has not successfully made that transition if the FSA or HRA coverage period does not end before the employer executes the qualified distribution since the employee is still

138.. I.R.S. Notice 2007-22, 2007-1 C.B. 670, 671.
139. *Id.* at 670.
140. *Id.*
141. *Id.*
142. *See id.* at 672.
143. *Id.*
144. *Id.*
145. I.R.C. § 223(c)(1) (CCH 2009).

"covered" by the arrangement.[146] This is true even if the arrangement has been completely depleted by the qualified distribution and is thus incapable of interfering with the accountholder's burden to pay the minimum deductible.[147] The result is that a qualified distribution may not be made tax-free from an FSA unless it has a grace period,[148] and a qualified distribution cannot be made from any arrangement unless it occurs at the end of the arrangement's coverage period.[149] The rules are further complicated by the fact that the employee must remain an HSA-eligible individual during a thirteen-month "testing period," beginning with the month of the qualified distribution.[150]

These rules make the qualified distribution seemingly unappealing despite Congress's commendable attempt to make HSAs more attractive. The problem is that, for the first time ever, the rules for HSAs must interact with the rules for FSAs and HRAs without violating each other. The consequence of failure is expensive: the employee must include the transferred funds in her gross income and pay an additional penalty tax.[151] The employee's failure to remain an eligible individual during the thirteen-month testing period could be even more expensive; in addition to these taxes, if the accountholder uses the transferred funds for anything other than qualified medical expenses, she will include the amount once again in her income and pay a second ten-percent penalty tax, despite the already hefty taxes imposed for the failed transfer.[152] For example, the accountholder would have to pay this additional penalty tax if she were to treat the failed distribution as an "excess contribution," for which the IRS requires the accountholder to not only include the amounts in her income, but also to withdraw the taxable funds from the HSA.[153] Accordingly, the accountholder must be conscious of the proper

146. I.R.S. Notice 2007-22, 2007-1 C.B. 670, 671.

147. *Id.* at 670–71.

148. I.R.C. section 125 prohibits deferred compensation for FSAs; therefore, funds in an FSA at the end of a plan year must be forfeited to avoid adverse tax consequences. An HSA distribution occurring at the end of the FSA coverage period is disallowed by the IRS because of this assumed forfeiture. Congress, however, in the amendments to HSA law, expressly allows an otherwise HSA-eligible individual during an FSA grace period to be considered HSA eligible as long as the FSA has a zero balance entering into the grace period. Therefore, an employee may make an HSA distribution from an FSA with a grace period. *Id.* at 671.

149. Eligible individuals may not participate in a health FSA or HRA; an HSA distribution mid-year does not end the employee's participation in the arrangement even if the arrangement is completely depleted of funds. Funds, transferred mid-year to an HSA, are not tax-free because the employee has failed to become an HSA-eligible individual by the time the transfer has been executed. *Id.*

150. I.R.C. § 106(e)(4) (CCH 2009).

151. I.R.S. Notice 2007-22, 2007-1 C.B. 670, 671.

152. *Id.*

153. *See Id.* ("Failing to remain an eligible individual does not require the withdrawal of the qualified HSA distribution, and the amount is not an excess contribution."); I.R.C. § 223(f)(3) (CCH 2009).

approach to rectifying an impermissible contribution, lest she become subject to exorbitant penalties.[154]

Yet, the testing period is not troubling merely because of the magnitude of the potential tax. The fact that well-intentioned accountholders can become ineligible individuals through no fault of their own is more startling. For example, an accountholder may involuntarily become unemployed and be left to choose between enrolling in COBRA, purchasing an HDHP in the individual market, or becoming HSA ineligible. None of these options are appealing. If the accountholder elects coverage through COBRA, she can keep her former employer's health plan but will most likely pay the monthly premium without help from her now-former employer.[155] In 2008, the average employer paid between seventy-one and eighty-nine percent of his employees' HDHP premiums.[156] Accordingly, an accountholder electing COBRA will likely pay more than twice the amount she was paying as an employee.[157] Further, while buying an HDHP in the individual market might be a less expensive alternative to COBRA, especially if the accountholder is under age fifty-five,[158] health insurance companies may deny her coverage if the accountholder has a pre-existing condition or offer her a policy that does not cover her prior condition.[159] Regardless, a newly terminated employee may simply be unable to afford any coverage, even at the less expensive price that she paid as an employee. In comparison, paying the hefty penalty tax for failing to survive the testing period may appear to be the

154. The IRS illustrates these consequences in an example in Notice 2008-52. I.R.S. Notice 2008-52, 2008-25 I.R.B. 1166, 1168. Even though Notice 2008-52 addresses the full contribution rule, both the qualified HSA distribution and the full contribution rule are subject to testing periods.

155. *See* Schwartz, supra note 89 ("The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) was designed to help people continue their health coverage after leaving a job. However, many workers find that after losing a job they are not able to afford the premiums required to continue employer-sponsored insurance through COBRA.").

156. The Kaiser Family Found. & Health Research & Educ. Trust, 2008 Annual Survey: Employer Health Benefits 86 (2008), http://ehbs.kff.org/pdf/7790.pdf. In 2008, covered workers on average contributed eleven percent of the HDHP premium for single coverage and twenty-nine percent of the HDHP premium for family coverage. Estimates include health plans with a deductible of at least $1,000 for single coverage and $2,000 for family coverage offered with an HRA. *Id.* at 4–5.

157. The average annual premium for top selling employer-provided HSA-compatible HDHPs during 2007 was slightly greater than $3,000 for a single policy and more than $8,000 for family coverage. Am. Health Ins. Plans, January 2008 Census Shows 6.1 Million People Covered by HSA/High-Deductible Health Plans 7–8 (2008),http://www.ahipresearch.org/pdfs/2008_HSA_Census.pdf http://www.ahipresearch.org/pdfs/2008_HSA_Census.pdf.

158. While the average annual premium for an HSA-compatible HDHP in the individual market during 2007 was $2,278 for persons thirty to fifty-four years old purchasing individual coverage, and $5,125 for family coverage, persons fifty-five and older paid an average of $3,724 and $7,170. *Id.* at 6.

159. *See* Wildsmith, *supra* note 90.

cheap way out.[160] This is an unfortunate result in light of the fact that, during the five year period that Congress allowed employees to elect a qualified distribution, the United States experienced a recession during which the country's unemployment rate soared to 10.2 percent, the highest it had been in twenty-six years.[161]

Not long after the IRS issued guidance addressing qualified distributions, the IRS received comment letters from various stakeholders accusing the IRS of taking a "narrow reading of the statute that results in several complex and restrictive rules."[162] One author stated that the complexity of the rules has lead the author's group to advise employers against offering qualified distributions to employees, even though the qualified distribution was a key part of Congressional efforts to encourage employees to establish HSAs.[163] In another letter, one insurer expressed concern that the complexity surrounding the rollovers could result in decreased interest in HSAs.[164] In a third letter, America's Health Insurance Plans (AHIP), a national association that represents nearly 1,300 health insurance plans covering more than two hundred million people,[165] stated that in certain situations, the IRS's requirements could "result in administrative difficulties for employers, unduly restrict the transfer of funds from a health FSA or HRA into an HSA, and require individuals to forfeit amounts in their [arrangement] that could be used to reimburse qualified medical expenses."[166]

The commentary addressing the administrative rules identified specific problems and proposed modifications to Notice 2007-22. Among the problems cited was the inability of employers to make qualified distributions

160. The amendments do, however, allow an exception to the testing period's tax penalty for the death or disability of the accountholder. Tax Relief and Health Care Act of 2006, Pub. L. No. 109-432, § 302, 120 Stat. 2922, 2948 (2006).

161. News Release, Bureau of Labor Statistics, The Employment Situation—October 2009 (Nov. 6, 2009), http://www.bls.gov/news.release/pdf/empsit.pdf (last visited Nov. 15, 2009).

162. *Insurer Seeks Simplification of HSA Rollover Rules*, 2007 TNT 85-12 (Apr. 17, 2007).

163. *HSA Coalition Claims Guidance Negates Recent Health Care Provisions*, 2007 TNT 56-21 (Mar. 6, 2007) [hereinafter *HSA Coalition*] ("[I]f the U.S. Treasury does not make some material change in this guidance, then our position of recommending that employers do not attempt an FSA or HRA to HSA rollover will not change.").

164. *Insurer Seeks Simplification of HSA Rollover Rules*, *supra* note 162 ("[W]e are concerned that overly restrictive guidance pertaining to HSAs, particularly this rollover guidance, could instead limit the growth of HSAs in the future.").

165. *AHIP Seeks Clarification on Treatment of Distributions to HSAs*, 2007 TNT 90-19 (Apr. 27, 2007) [hereinafter *AHIP*].

166. *Id.*

from any arrangement mid-year;[167] the prohibition against making a qualified distribution from an FSA without a grace period;[168] and the inherent conflict between the IRS's requirement to determine the arrangement's balance on a cash basis and insurers' administrative practices.[169] One comment letter suggested leaving the rules mostly intact but permitting employers to hold the HSA distribution in a frozen sub-account for up to twelve months.[170] That plan would allow the employer to wait for the employee to become an HSA-eligible individual before depositing the sub-account's funds into the employee's newly established HSA.[171] In another comment letter, the writer recommended that the IRS adopt an alternative method to the qualified distribution: allow the employee to decide the amount to transfer from the arrangement, at any time during the plan year, as long as the amount does not exceed the balance in the arrangement on September 21, 2006; permit the employer to hold the funds in a special account that the employer or a trustee maintains until the end of the plan year that the employee cannot access; and permit any remaining funds in the arrangement to be used solely for the payment of the employee's unreimbursed medical claims, even after the plan year ends.[172]

The IRS did not adopt any of these "solutions." This result is not surprising. The troubled qualified distribution does not owe its problems to the IRS; the Service merely employed the rules that *Congress* prescribed in a manner that would not conflict with the rules for HRAs, FSAs, and HSAs. The IRS prohibits qualified distribution from FSAs that do not have a grace period in Notice 2007-22 because Congress failed to address the FSA "use-it-or-lose-it" rule in the amendments.[173] This rule requires that unused funds remaining in the FSA at the end of the plan year be "forfeited" because the FSA would otherwise allow employees to "defer compensation."[174] The result is that funds in an FSA without a grace period cannot be transferred to

167. *HSA Coalition*, *supra* note 163 ("The IRS imposes a third condition that effectively eviscerates the Act for employers that hold open enrollment for health coverage in the middle of the year.").

168. *Id.*

169. *AHIP*, *supra* note 165.

170. *Insurer Seeks Simplification of HSA Rollover Rules*, *supra* note 162.

171. *Id.*

172. *AHIP*, *supra* note 165. This approach includes a requirement that the employee agrees to terminate his or her participation in the arrangement at the end of the plan year if the arrangement is not otherwise converted to an HSA-compatible arrangement. *Id.*

173. *See* I.R.S. Notice 2007-22, 2007-1 C.B. 670, 671; *HSA Coalition*, *supra* note 163.

174. I.R.S. Notice 2005-42, 2005-1 C.B. 1204 ("[A] cafeteria plan does not include any plan that defers the receipt of compensation or operates in a manner that enables participants to defer compensation by, for example, permitting participants to use contributions for one plan year to purchase a benefit that will be provided in a subsequent plan year. This rule is commonly referred to as the 'use-it-or-lose-it' rule, requiring that unused contributions or benefits remaining at the end of the plan year be 'forfeited.'").

an employee's HSA *before* the FSA plan year ends because the employee is still covered by the FSA and thus is not an HSA-eligible individual. Further, an employer may not transfer funds *after* the FSA plan year ends because the amounts disappear as a consequence of the "use-it-or-lose-it" rule.[175]

Furthermore, the IRS may have declined to adopt the sub-account approach due to the rules for HRAs and FSAs that limit movement of arrangement funds. Generally, money may only be removed from either arrangement tax-free for Code section 213(d) qualified medical expenses.[176] Funds can be transferred to an HSA through a qualified distribution only because Congress modified HRA and FSA law in the 2006 amendments to allow an exception for balance transfers to an HSA.[177] Accordingly, moving money from an arrangement to a special sub-account that is not an HSA would be impermissible since the transfer would neither qualify as reimbursement for a Code section 213(d) qualified medical expense nor be considered a qualified HSA distribution. Congress should have addressed these problems, and others, when enacting the amendments. Not surprisingly, it was Congress that responded.

### 2. Congress's Response

Congress was not unsympathetic to the public's concerns. In 2008 two distinct bills, one introduced in the Senate and the other in the House of Representatives, sought to amend HSA law once again.[178] Each bill contained provisions offering different "solutions" to the controversial qualified HSA distribution. First, Republican Representative Sali from Idaho introduced the American Health Care Access Improvement, Portability and Cost Reduction Act of 2008 in the House on September 26, 2008.[179] The House bill proposed amending Code section 106 to overlook the "use-it-or-lose-it" rule for FSAs

175. I.R.S. Notice 2007-22, 2007-1 C.B. 670, 671 ("Thus, if a health FSA does not have a grace period, unused amounts remaining at the end of the plan year are forfeited and generally cannot be transferred through a qualified HSA distribution to an HSA after the end of the plan year.").

176. I.R.C § 105(b) (CCH 2009).

177. Tax Relief and Health Care Act of 2006, Pub. L. No. 109-432, § 302, 120 Stat. 2922, 2948 (2006) ("A plan shall not fail to be treated as a health flexible spending arrangement or health reimbursement arrangement under this section or section 105 merely because such plan provides for a qualified HSA distribution.").

178. H.R. 7166, 110th Cong. (2008) (American Health Care Access Improvement, Portability, and Cost Reduction Act of 2008); S. 3626, 110th Cong. (2008) (Family and Retirement Health Investment Act of 2008). Note that the House bill was introduced in the 110th Congress. As of November 2009, many of the sections within the bill had not appeared in any of the legislation introduced in the 111th Congress. However, the relevant sections of the Senate bill are contained in H.R. 3508, the "Healthy Savings Act of 2009."

179. H.R. 7166, 110th Cong. (2008).

in the case where the employee obtains a qualified distribution,[180] thereby permitting employees and employers to make qualified distributions from FSAs that do not have grace periods. The House bill would also resolve the issues regarding the requirement that the arrangement be completely depleted upon execution of the qualified distribution: Code section 106 would be further amended to permit remaining funds in the arrangements to be deposited into HSA-friendly arrangements, such as the post-deductible or the post-retirement HRA or FSA.[181] Finally, the House bill would further resolve potential issues arising from the qualified distribution by amending Code section 223 to include the HRA and FSA as "disregarded coverage" as long as the employee "disclaimed" the arrangement when establishing the HSA.[182]

While these modifications simplify the qualified distribution, the House bill fails to address some important problems. First, it fails to help employees who are excluded from making a qualified distribution because of a job change between September 21, 2006, and the date of a qualified distribution. Second, it does not help those employees who had an arrangement on September 21, 2006, but had already depleted the arrangement by that date. Finally, the changes do not address the unfair penalty tax for involuntarily terminated employees who are in danger of failing the testing period.[183]

House Bill 7166, however, goes a great step further to advance the purpose of the 2006 HSA amendments by promoting a peaceful, though temporary, coexistence among the three CDHC plans by adding FSAs and HRAs to Code section 223's "disregarded coverage."[184] The provision would only be available for five years after the House bill's proposed enactment (for

180. .Section 12(a) of the House bill would insert, at the end of I.R.C. section 106(e)(2), "[a] distribution shall not fail to be treated as a qualified HSA distribution merely because the balance in such arrangement is determined without regard to the requirement that unused amounts remaining at the end of a plan year must be forfeited in the absence of a grace period." *Id.* § 12(a).

181. Section 12(b) of the House bill would amend I.R.C. section 106(e)(1) to include the following provision: "[a]nd the deposit of funds in excess of a qualified HSA distribution amount into a health flexible spending account or health reimbursement arrangement which is compatible with a health savings account and which, on the date of such distribution, is part of the employer's plan." *Id.* § 12(b).

182. .Section 12(c) of the House bill would amend I.R.C. section 223(c)(1)(B) to include, at the end, "(iv) any coverage (whether actual or prospective) otherwise described in subparagraph (A)(ii) which is disclaimed at the time of the creation or organization of the health savings account." *Id.* § 12(c).

183. Note that H.R. 7166 also includes provisions unrelated to the qualified HSA distribution that would further expand the use of HSAs. First, the bill would remove the prohibition under Code section 223 against using HSA dollars for insurance premiums by striking sections 223(d)(2)(B)–(C). *Id.* § 7. Second, the bill would permit an HSA accountholder to contribute catch-up contributions to her HSA for both her and her spouse if the spouse does not own an HSA and if both spouses are fifty-five years old or older. *Id.* § 11. Third, H.R. 7166 would double the annual maximum HSA contribution limits. *Id.* § 6. Finally, the bill would allow eligible individuals to enroll in Medicare Part A. *Id.* § 9.

184. *Id.* § 5(a).

taxable years beginning prior to 2013).[185] During the five-year period, accountholders would be discouraged from abusing this benefit, and potential loss of tax revenue would be minimized, by limiting the annual combined tax-free funds to the value of the accountholder's out-of-pocket maximum;[186] specifically, the House bill would permit the employee to maintain, in one or more arrangements, the difference between her HDHP's out-of-pocket maximum and the annual maximum HSA contribution for her coverage type.[187]

There are four advantages to this approach. First, in accordance with the 2006 HSA amendments, employees who are happy with their HRA or FSA would be given an incentive to establish an HSA for the first time. Allowing these employees to keep their current coverage under their arrangements while enabling them to enroll in HSAs constitutes minimal risk for them and is probably an easier transition than that which the qualified distribution offers. Second, by relying in part on coverage through an FSA or HRA, these employees would be able to accumulate funds in their HSAs during their initial years as HSA accountholders. These HSA funds could later offset any unforeseen catastrophic events, such as an emergency room visit or surgery.[188] Third, the House bill imposes a time limit; accordingly, opportunities for abuse by the accountholder and an increased loss of tax revenue are minimized. Fourth, the time limit provides a sense of urgency for HRA and FSA participants to establish an HSA, thereby encouraging quick growth for the HSA. Finally, the amendment would resolve all the aforementioned problems cited in the commentaries to the IRS by permitting concurrent coverage during the period of time in which Congress permits qualified distributions.

However, the House bill fails to address the administrative complexity which would result from this approach. Specifically, the House bill does not indicate which party would determine and monitor the maximum amount

185. *Id.* §§ 5(b)–(c).

186. *Id.* § 5(b).

187 .*Id.* To illustrate, the 2010 HSA maximum contribution for self-only HDHP coverage is $3,050. If the House bill had been enacted, an accountholder with self-only coverage that limits out-of-pocket expenses to $5,000 could receive an aggregate of $1,950 in one or more arrangements. Note that the calculation provided under section 5(b) of H.R. 7166 does not take into consideration funds in a limited-purpose HRA or FSA. *Id.*

188.. The IRS has provided a limited incentive for HRA and FSA participants to establish HSAs by issuing I.R.S. Rev. Rul. 2004-45, which allows certain HSA compatible arrangements. For example, an employer may convert its employee's general health HRA into a post-deductible HRA which, combined with the employee's HSA funds, allows her to use tax-free dollars to pay for her out-of-pocket expenses under her HDHP. However, unlike permitting concurrent coverage as offered by H.R. 7166, this option does not allow the employee to save her HSA funds for future expenses.

that the employee keeps in an HRA or FSA during the plan year. If the employee is allowed to monitor the limit without any oversight, abuse would be too easy. The employee could exceed the limits unless the IRS can determine a means for monitoring all amounts available to the employee through HRAs and FSAs. If the employer is delegated this role, it would undoubtedly be an excessive burden to keep track of what could potentially be thousands of employees' HRAs and FSAs. In the case where the employer provides the employee with an HRA or FSA and the HDHP, the math is relatively simple since the employer knows both the employee's out-of-pocket maximum and the statutory annual HSA maximum for the employee's coverage type. However, calculating the maximum HRA or FSA contributions becomes increasingly complex if the employer offers a variety of HDHPs with different out-of-pocket maximums and provides employees with the option to participate in both an HRA and FSA. Greater complications arise when the employee's spouse also has an HRA or FSA through a different employer to which the employee has access. Delegating this role to employers would essentially require employers to monitor multiple HRAs and FSAs, some of which might be provided by a different employer. This obviously would lead to absurd results. Further, the House bill fails to address potential abuse; it does not impose a penalty tax for contributions in excess of the allowed amounts.[189] Unfortunately, unless Congress resolves these issues, enactment could result in as many administrative obstacles as there currently are for the qualified distribution.

The Senate proposal offers a different approach. On the same day that the House bill was introduced, Senator Hatch introduced the Family and Retirement Health Investment Act of 2008 in the Senate.[190] Similar to the House bill, the Senate bill would amend the Internal Revenue Code to permit qualified distributions from FSAs that do not have a grace period; however, it would accomplish this goal more appropriately by changing Code section 125, the section to which the "use-it-or-lose-it" rule applies.[191] The Senate bill would also provide an opportunity for qualified distributions to occur during a plan year;[192] disregarded coverage within Code section 223 would

189. *See* H.R. 7166 § 5(b).

190. S. 3626, 110th Cong. (2008).

191. *Id.* § 6(c). The Senate bill would add, at the end of I.R.C. § 125(d)(2), "(E) EXCEPTION FOR QUALIFIED HSA DISTRIBUTIONS.—Subparagraph (A) shall not apply to the extent that there is an amount remaining in a health flexible spending account at the end of a plan year that an individual elects to contribute to a health savings account pursuant to a qualified HSA distribution (as defined in section 106(e)(2))." *Id.*

192. I.R.S. Notice 2007-22 provides that "qualified HSA distributions from health FSAs or HRAs that are not HSA-compatible and that take place at any time other than the end of a plan year, generally

include an HRA or FSA as long as (1) the employee obtains a qualified distribution during the year, and (2) the arrangement is limited to HSA compatible coverage for the remainder of the year, such as preventive care, permitted insurance, and post-deductible expenses.[193]

Even more notably, the Senate bill would resolve the problems arising from the complex "lesser-of" balance rule for qualified distributions by eliminating it.[194] Instead, if the arrangement is an FSA, the Senate bill would allow employers to transfer an employee's FSA balance at the time of the qualified distribution, but not to exceed $2,250 for an employee with self-only HDHP coverage or $4,500 for an employee with family coverage.[195] For qualified distributions made from an HRA, the bill would allow employers to transfer an employee's balance at the time of the qualified distribution, but not to exceed a maximum amount which is determined by multiplying the number of months that the employee was an HRA participant by $187.50 if the employee is enrolled in self-only coverage or by $375 if she is enrolled in family coverage.[196]

The Senate bill also addresses the unfairness of the testing period for those accountholders who involuntarily lose their status as HSA-eligible individuals by revoking altogether the testing period for qualified distributions.[197] Finally, the Senate bill addresses the public's concern that conversion of an HRA or FSA to an HSA-compatible arrangement (to facilitate the qualified distribution) would affect other employees who are not transitioning to the HSA.[198] The Senate bill would amend Code section 106(e) to permit the immediate conversion of a general health arrangement to an HSA-compatible arrangement for those making a qualified distribution while expressly providing that the conversion does not require a change in coverage for employees who do not enroll in an HDHP.[199]

The Senate bill would undoubtedly resolve some of the contention surrounding the qualified distribution, but it would also invite new concerns. First, the modification would fail to discourage abuse because it revokes the strict testing period altogether. It would be more prudent to exempt accountholders who involuntarily become ineligible from the testing period's

result in the inclusion of the distribution in income and the imposition of an additional 10 percent tax." I.R.S. Notice 2007-22, 2007-1 C.B. 670, 671.

193. S. 3626 § 6(a).
194. *Id.* § 6(d).
195. *Id.*
196. *Id.*
197. *Id.* § 6(e).
198. *Id.* § 6(f).
199. *Id.*

penalty tax. To do so would be consistent with current exceptions for those who involuntarily become ineligible due to death or disability.[200] Thus, abuse would be discouraged, while those who become ineligible for involuntary reasons would not be unfairly penalized.

Second, the simplified qualified distribution in the Senate bill does not include a time limit, unlike current law, which requires all rollovers be carried out by January 2012.[201] In other words, the modifications that the Senate bill proposes would repeal the current time limit while declining to introduce a new one. Arguably, an accountholder could shift from HSA eligible to ineligible over time to take advantage of multiple qualified distributions over the course of her employment. This abusive practice is worsened by the fact that the amounts rolled over would not be subject to the HSA annual maximum contribution.[202] The Senate bill would be strengthened by limiting accountholders to one qualified distribution during the lifetime of the accountholder.[203]

However, the best solution is to repeal the troubled qualified distribution. Instead, Congress should permit employees who are currently enrolled in an HRA or FSA to enroll in an HSA, as proposed by the House bill.[204] By permitting temporary concurrent coverage, Congress would give effect to the purpose of the 2006 HSA amendments; those individuals who do not have an HSA would be encouraged to enroll in an HDHP and establish an HSA without requiring them to forfeit the funds in their HRAs and FSAs. Accordingly, employees who take advantage of the opportunity could continue to use their current arrangements while saving up money in their HSAs for future catastrophic medical expenses. This approach would give employees a head start. However, Congress must find a workable method for tracking the aggregate contributions in the FSAs, HRAs, and HSAs that is not too burdensome to employers and which would discourage and prevent abuse. Accordingly, Congress should impose a penalty on those who do exceed the annual limits. Moreover, to simplify the administration of these arrangements, Congress should limit employees to keeping only one HRA or FSA

200. I.R.C § 106 (e)(3)(B) (CCH 2009).

201. The Senate bill rewrites subsection 106(e)(2). S. 3626 § 6(d). The new version of the subsection excludes the current provision under section 106(e)(2)(B), which provides that the qualified HSA distribution "is contributed by the employer directly to the health savings account of the employee before January 1, 2012." I.R.C § 106 (e)(2)(B).

202. I.R.S. Notice 2007-22, 2007-1 C.B. 670 ("Qualified HSA distributions are not taken into account in applying the annual limit for HSA contributions.").

203. Note that the bill would limit an accountholder to one qualified distribution from each arrangement. S. 3626 § 6(d).

204. H.R. 7166, 110th Cong. § 5 (2008).

in combination with their HSAs and HDHPs. Additionally, the HDHP and the arrangement should be provided by the same employer.

### *B. Congress or the IRS Should Clarify the Meaning of Preventive Care.*

The HSA-compatible high-deductible health plan has already embarked towards the goal of modern health care reform: improved preventive care.[205] While there are many differences between the advocated approaches to health care reform during the twenty-first century, there is general consensus that preventive care plays an important role.[206] For example, Senator Max Baucus, the chairman of the Senate Finance Committee, focused on preventive care as a short-term goal in his 2009 health care reform white paper, "Call to Action."[207] In his proposal, Senator Baucus observed that the quality of health care will increase, and the overall cost of America's health care system will decrease, by shifting our nation's attention away from treating illness to preserving wellness.[208]

Similarly, Senators Ron Wyden and Bob Bennett's bipartisan bill, the Healthy Americans Act,[209] declares that American health care provides primarily sick care and fails to do enough to prevent chronic illnesses like heart disease, stroke, and diabetes, which consequently results in significantly higher health costs for Americans.[210] The Healthy Americans Act would make preventive care a key feature in all health insurance plans, in part by requiring that the plans provide coverage for preventive care notwithstanding the health plan's deductible.[211] During Senate proceedings immediately following the introduction of his bill, Senator Wyden spoke about the Healthy

205. Code section 223(c)(2)(C) provides that an HDHP need not have a deductible for preventive care. I.R.C. § 223(c)(2)(C) (CCH 2009).

206. For example, the Affordable Health Care for America Act prohibits cost-sharing under its essential benefits package for certain preventive services. H.R. 3962, 111th Cong. § 222(c)(1) (2009) (placed on calendar in Senate).

207. Sen. Max Baucus, Call to Action: Health Reform 2009 14 (Nov. 12, 2008), *available at* http://finance.senate.gov/healthreform2009/finalwhitepaper.pdf.

208. *Id.*

209. S. 391, 111th Cong. (2009). The Healthy Americans Act proposes that each state provide a minimum of two standard health plans modeled after the Federal Employees Health Plan. *Id.* § 111(a). The bill would preserve HSAs and would modify the high deductible health plan to meet standard benefits requirements enumerated within the bill. *Id.* § 665(d).

210. *Id.* § 2 (findings).

211. The bill proposes requiring plans to have certain standard health insurance benefits, including wellness programs and incentives to promote the use of such programs; designation of a qualified health provider who would determine a care plan to maximize the health of the individual through wellness and preventive activities; and comprehensive disease prevention and management benefits. *Id.* § 111(b). Because the HSA compatible HDHP would be required to conform to a standard benefit design, the HDHP would go further than merely permitting first dollar coverage for preventive care, as current law provides; as a standard plan, the HDHP would be required to provide first-dollar coverage for preventive care, disease management, and chronic pain treatment. *Id.*

Americans Act and said about health care reform in general: "[I] believe strongly that fixing American health care requires a new ethic of health care prevention, a sharp new focus in keeping our citizens well, and trying to keep them from falling victim to skyrocketing rates of increase in diabetes, heart attack, and strokes."[212] President Obama also advocated prevention as an important element of health care reform in his health care agenda.[213]

The HSA has already made progress in this area. Undoubtedly, one of the strengths of HSAs is the HDHP's unique focus on preventive care.[214] In designing the rules for HSA-compatible HDHPs, Congress must have recognized that prevention can lower health care costs, a crucial goal for CDHC and, specifically, HSAs. Indisputably, that goal is shared by insurers, consumers, and employers; a recent survey conducted by America's Health Insurance Plans indicates that eighty-four percent of all HSA compatible HDHPs on the market take advantage of the option to exempt preventive care from the HDHP's deductible.[215]

However, exactly which medical services qualify as "preventive" has been an important question, difficult to answer and, to date, still unclear. The problem originates from the fact that Congress only provided one short subsection within Code section 223 that addresses preventive care; that subsection states that a health plan does not fail to be an HDHP merely because it does not have a deductible for "preventive care . . . within the meaning of section 1871 of the Social Security Act, except as otherwise provided by the Secretary."[216] But section 1871 does not define preventive care. In fact, not even Code section 213, which addresses tax-deductible medical expenses, provides a definition. Consequently, the task of defining preventive care was left to the IRS, which was not slow to respond; almost immediately after codification of section 223, the IRS requested public commentary on a number of matters concerning HSAs, including the appropriate standard for preventive care.[217] The immediate interest was noteworthy. The IRS received

212. 153 Cong. Rec. S757 (daily ed. Jan. 18, 2007) (statement of Sen. Wyden).

213. *See* Obama-Biden, Barack Obama and Joe Biden's Plan To Lower Health Care Costs and Ensure Affordable, Accessible Health Coverage for All, http://www.barackobama.com/pdf/issues/HealthCareFullPlan.pdf (last visited Nov. 12, 2009).

214. I.R.C. § 223(c)(2)(C) (CCH 2009).

215. Am. Health Ins. Plans, A Survey of Preventive Benefits in Health Savings Account (HSA) Plans, July 2007 (2007), http://www.ahipresearch.org/pdfs/HSA_Preventive_Survey_Final.pdf.

216. I.R.C. § 223(c)(2)(C).

217. I.R.S. Notice 2004-2, 2004-1 C.B. 269, 273.

letters from stakeholders, including the health insurance industry,[218] interest groups,[219] and benefit consultants.[220]

Generally, the commentary recognized that no universal standard for preventive care existed,[221] the term "preventive care" was vague, and clarification of the term's meaning was necessary since the MMA did not define preventive care when creating Code section 223.[222] The solution advocated by nearly all commentators was to adopt a flexible and broad definition[223] so that preventive care could adapt as the HSA market develops and keep pace with advances in medical technology and health care clinical knowledge, thus fostering innovation.[224] Some commentary advocated allowing the health plans and their sponsors to determine which medical services are preventive.[225] By deferring to the private market, HDHPs could arguably conform to the needs of various industries, to geography, and to workforce demographics.[226]

Additionally, many comment letters included either a recommendation to exempt prescription drugs from the deductible or a recommendation to

218. *E.g.*, *American Medical Ass'n Comments on HSA, HDHP Guidance*, 2004 TNT 46-24 (Feb. 25, 2004) [hereinafter *AMA Comments on Guidance*]; *Blue Cross/Blue Shield Comments on HSA, HDHP Guidance*, 2004 TNT 46-25 (Feb. 26, 2004) [hereinafter *BCBS Comments on Guidance*]; *Fortis Health Discusses Health Savings Accounts*, 2004 TNT 10-41 (Dec. 19, 2003) [hereinafter *Fortis*]; *Health Care Company Offers Definition of 'Preventive Care*,*'* 2004 TNT 58-48 (Mar. 16, 2004) [hereinafter *Health Care Company*]; *United Health Group Comments on HSA Guidance*, 2004 TNT 53-31 (Mar. 9, 2004) [hereinafter *UHG Comments on Guidance*]; *WellPoint Highlights HSA Issues Needing Immediate Attention*, 2004 TNT 71-24 (Mar. 18, 2004) [hereinafter *WellPoint*]; *Writer Recommends Additional HSA Guidance*, 2004 TNT 39-17 (Feb. 13, 2004) [hereinafter *Writer Recommends Guidance*].

219. *E.g.*, *Benefit Administrators Offer Definition of 'Preventive Care' Under HSAs*, 2004 TNT 54-23 (Mar. 11, 2004) [hereinafter *Benefit Administrators*]; *Benefits Council Seeks Clarity in HSA Rules*, 2004 TNT 40-69 (Feb. 24, 2004); *Coalition Comments on HSAs*, 2004 TNT 62-36 (Mar. 16, 2004); *Council Shares Responses to FAQs on HSAs*, 2004 TNT 57-25 (Mar. 12, 2004) [hereinafter *Council Shares Responses*]; *Doctor Comments on HSAs*, 2004 TNT 22-76 (Jan. 10, 2004); *Group Comments on HSA Guidance*, 2004 TNT 48-26 (Mar. 5, 2004); *Insurance Agent Council Comments on HSAs*, 2004 TNT 62-38 (Mar. 18, 2004).

220. *E.g.*, *Deloitte Consulting Comments on HSAs*, 2004 TNT 61-23 (Mar. 24, 2004) [hereinafter *Deloitte Comments*]; *Human Resources Company Comments on HSAs and HDHPs*, 2004 TNT 38-25 (Feb. 16, 2004) [hereinafter *HR Company Comments*].

221. *Doctor Comments on HSAs*, 2004 TNT 22-76.

222. *See Fortis*, *supra* note 219; *UHG Comments on Guidance, supra* note 219; *Writer Recommends Guidance*, *supra* note 219.

223. *See e.g.*, *WellPoint*, *supra* note 219; *UHG Comments on Guidance*, *supra* note 219; *Writer Recommends Guidance, supra* note 219; *Fortis*, *supra* note 219.

224. *AMA Comments on Guidance*, *supra* note 219; *accord e.g.*, *Group Comments on HSA Guidance*, *supra* note 220 ("A detailed definition of preventive care quickly will become outdated. A broad definition will allow HDHPs to be amended as necessary."); *UHG Comments on Guidance*, *supra* note 219 ("Treasury should adopt a sufficiently broad and flexible definition that allows for development of new preventive care services and changes in preventive care standards.").

225. *E.g.*, *Benefits Council Seeks Clarity in HSA Rules*, *supra* note 220; *Group Comments on HSA Guidance*, *supra* note 220; *WellPoint*, *supra* note 219.

226. *WellPoint*, *supra* note 219.

permit first dollar stand-alone prescription drug plans in conjunction with an HDHP as long as the latter did not provide coverage for prescription drugs.[227] Not uncommonly, this recommendation was supported in part by claims that the plain language of the statute permitted the pairing and, thus, nothing prevented the IRS from concluding that the pairing was permissible.[228] However, other recommendations suggested a narrower interpretation of preventive care that adopts methods currently in use. Specifically, some commentators suggested referring to the United States Preventive Services Task Force (USPSTF) recommendations on what should be considered "preventive care," to the American Medical Association (AMA) CPT codes that identify specific care and services as "preventive,"[229] or to "nationally recognized 'preventive' treatment guidelines, such as those put forward by the Advisory Committee on Immunization Practices (ACIP) and other medical professional organizations."[230]

The IRS responded by issuing Notice 2004-23.[231] The IRS listed a limited number of preventive services in the notice, such as annual physicals, immunizations, routine prenatal and well-child care, tobacco cessation programs, and obesity weight-loss programs.[232] However, the list is not exhaustive,[233] and the guidance only goes as far as to state that preventive care "does not generally include any service or benefit intended to treat an existing illness, injury, or condition."[234] Later that same year, the IRS provided an exception to this rule for any service that is intended to treat an illness, injury, or condition that is "ancillary" or "incidental" to a preventive service, and "where it would be unreasonable or impracticable to perform another procedure to treat the condition."[235] These types of ancillary or incidental services, according to the IRS, fall within the "safe-harbor for preventive

227. *BCBS Comments on Guidance*, *supra* note 219; *Group Comments on HSA Guidance*, *supra* note 220; *HR Company Comments*, *supra* note 221; *UHG Comments on Guidance*, *supra* note 219; *WellPoint*, *supra* note 219.

228. *E.g.*, *Benefits Council Seeks Clarity in HSA Rules*, *supra* note 220; *HR Company Comments*, *supra* note 221; *Insurance Agent Council Comments on HSAs*, *supra* note 220; *but see AMA Comments on Guidance, supra* note 221 (citing three reasons for subjecting prescription drug to the HDHP deductible: "[l]imiting the types of benefits that may be covered prior to meeting the deductible (1) preserves HSA incentives for patients to utilize health care services in a cost-conscious manner; (2) keeps premium costs down, thereby making HSAs affordable to more individuals; and (3) averts an invitation for States to mandate first-dollar coverage of the specified benefits.").

229. *UHG Comments on Guidance*, *supra* note 220; *Coalition Addresses Lingering HSA Issues With Treasury*, 2004 TNT 92-43 (Jan. 16, 2004).

230. *UHG Comments on Guidance*, *supra* note 219.

231. I.R.S. Notice 2004-23, 2004-1 C.B. 725.

232. *Id.*

233. *Id.*

234. *Id.*

235. I.R.S. Notice 2004-50, 2004-2 C.B. 196, 201(Q&A 26).

care," and the HDHP may therefore cover them notwithstanding the deductible.[236] The IRS provides the example of a non-preventive procedure to remove polyps that the doctor discovers during a diagnostic colonoscopy.[237]

Furthermore, in Revenue Ruling 2004-38, the IRS declined to allow eligible individuals to enroll in stand-alone prescription drug plans unless the plans delay coverage for the drugs until after the minimum statutory annual deductible is met, thereby subjecting prescription drug coverage to the HDHP deductible and out-of-pocket limitation requirements.[238] In Notice 2004-50, the IRS recognized that some prescription drugs can be "preventive" and therefore exempt from the HDHP deductible under Code section 223's safe harbor for preventive care.[239] The IRS proceeded to define preventive drugs as those drugs that an individual uses because she has "developed risk factors for a disease that has not yet manifested itself or not yet become clinically apparent (*i.e.*, asymptomatic), or to prevent the reoccurrence of a disease from which [she] has recovered."[240] However, preventive drugs are not "those drugs or medications used to treat an existing illness, injury or condition."[241]

It was appropriate for the IRS to refuse to allow eligible individuals to enroll in separate prescription drug plans that provide coverage before the statutory minimum deductible has been met. It is true that Code section 223 appears to permit an eligible individual to have a separate prescription drug plan in the case where her HDHP excludes coverage for prescription drugs; section 223 expressly prohibits eligible individuals from having any health insurance coverage which is not an HDHP *if* the non-HDHP "provides coverage for any benefit which is [also] covered under the [HDHP]."[242] Consequently, if a person's HDHP does not cover a particular benefit such as prescription drugs, a separate non-HDHP health plan that provides only that benefit would be permissible for purposes of qualifying the person as an eligible individual.

However, that interpretation would undermine the purpose of the HDHP requirement and the "eligible individual" requirement since conceivably any person could have two separate health plans, one that has a low deductible and covers almost all health benefits and an HDHP that covers very few benefits but subjects them to the high deductible and out-of-pocket

236. *Id.*
237 .*Id.*
238. Rev. Rul. 2004-38, 2004-1 C.B. 717.
239. .I.R.S. Notice 2004-50, 2004-2 C.B. 196, 201 (Q&A 27).
240. *Id.*
241. *Id.*
242. I.R.C §§ 223(c)(1)(A)(I)–(II) (CCH 2009).

requirements. Since Code Section 223 generally does not regulate the type or the number of benefits that the HDHP must cover, stripping the HDHP down in this manner to avoid subjecting most benefits to a high deductible would be permissible. The result would be that the HDHP could become a mere shell for nothing more than qualifying an individual for an HSA. This result would be absurd and contrary to the purpose of Code section 223.[243] Accordingly, the IRS's approach regarding prescription drug plans was appropriate.

On the whole, however, the IRS could have taken a more conservative approach to defining preventive care. Understandably, the IRS compromised by neither leaving the private market to completely define the term "preventive" nor imposing a narrow definition that the commentators argued would stifle innovation and prevent HDHPs from conforming to the needs of various industries, to geography, and to workforce demographics. Yet, by declining to defer to standards provided by the USPSTF or to the AMA's CPT codes, the IRS has left a substantial degree of uncertainty as to the complete extent of "preventive care." The IRS or Congress should defer to these standards. By doing so, they would provide the public with a definition that would promote consistency across HDHP designs. Further, this approach would provide predictability for employers and insurers. Currently, if either wishes to cover a particular service or procedure that is not indisputably "preventive," the insurer or employer may elect to subject the service or procedure to the plan's deductible to ensure compliance. Furthermore, by deferring to the USPSTF or the AMA's CPT codes, the IRS would help to ensure that accountholders' HDHPs are compliant. This is the most important of all the benefits, considering that, at the end of the day, it is the HSA accountholder who suffers the adverse tax consequences of a noncompliant HDHP. Finally, by adopting this approach, the IRS or Congress would enable the HDHP to act as a standard for future health care reform designs that make prevention a key factor.

The importance of establishing a reliable and consistent standard for preventive care beyond what was accomplished by the 2004 guidance is illustrated by current efforts to expand the definition to include prescription drugs that stop the progression of chronic illness and disease. A comment letter to the IRS identified ambiguity in the IRS's definition of preventive

243. This concern might have played a role in the IRS's decision to prohibit separate stand-alone prescription drug plans in combination with an HDHP. *See United Health Group Comments on HSA Guidance*, *supra* note 219 ("In interpreting the HSA statute, Treasury understandably wishes to prevent a slippery slope of benefit carve-outs that minimize the need that an HSA participant has for coverage under the high deductible health plan.").

care.[244] The letter points out that "[t]here is a need for further guidance on the scope of preventive care because the current guidance defining when drugs are used for preventive care is unclear."[245] The author points out an inconsistency between the IRS's definition of "preventive drug" and the example that accompanies the definition.[246] Generally, the definition provides that drugs used by an asymptomatic individual who has developed risk factors for a disease or illness are preventive and that drugs used to treat an existing illness or disease are not preventive.[247] The example that accompanies this definition provides a scenario in which the drug qualifies as preventive: cholesterol-lowering medication for a person who does not have heart disease.[248] The author argues that high cholesterol, while a risk factor for heart disease, is also an "illness" or "disease" that is treated, in the example, by the cholesterol-lowering medication.[249] The author recommends that the IRS issue new guidance permitting prescription drugs to be considered preventive when taken by a person to prevent a disease or the further progression of a chronic disease.[250] The author further notes a number of benefits to this approach, arguing that it "is highly desirable and cost effective to encourage the treatment" of risk factors for chronic illnesses and disease and that the expanded definition would prevent both "further disease progression and higher total healthcare costs."[251] A recent Senate bill agrees. The bill, the Family and Retirement Health Investment Act of 2008, would expand "preventive care" to include prescription drugs that have the "primary purpose of preventing the onset of, further deterioration from, or complications associated with chronic conditions, illnesses, or diseases."[252]

The IRS has not responded to these issues, and the current definition of preventive care as provided by the previously issued guidance remains unaltered. Congress and the IRS should decline these invitations to expand preventive care to include medications that treat chronic illness and disease. First, expansion of the definition of preventive care to include all chronic

244. *Attorney Seeks Inclusion of Guidance Project on Definition of Preventive Care in IRS Business Plan*, 2008 TNT 30-18 (Jan. 22, 2008).

245. *Id.*

246. *Id.*

247. I.R.S. Notice 2004-50, 2004-2 C.B. 196, 201 (Q&A 27).

248. *Id.*

249. *Attorney Seeks Inclusion of Guidance Project on Definition of Preventive Care in IRS Business Plan*, *supra* note 245.

250. *Id.*

251. *Id.*

252. S. 3626, 110th Cong. § 9 (2008) ("Preventive care shall include prescription and over-the-counter drugs and medicines which have the primary purpose of preventing the onset of, further deterioration from, or complications associated with chronic conditions, illnesses, or diseases."). The Healthy Savings Act of 2009 also includes this provision. H.R. 3508, 111th Cong. § 9 (2009).

illness medications would remove "much of the motivation to engage the consumer in lifestyle options which may reduce their reliance on medication or to move from one medication to another which might be as effective but less costly."[253] Second, keeping the current definition would keep HDHP premiums low, "thereby making HSAs affordable to more individuals."[254]

Rather, the IRS should limit the scope of preventive medications and rectify the apparent inconsistencies in Notice 2004-50[255] by leveraging the current exception for ancillary and incidental treatment. The IRS should clarify that the treatment of risk factors, regardless of whether the risk factor is a disease or an illness, is considered "ancillary" or "incidental" to the prevention of chronic disease when taken for the primary purpose of preventing the disease in an asymptomatic individual. Expanding the IRS's exception for treatment that is ancillary or incidental to the prevention of chronic disease would require minimal modification to current guidance and would fit neatly within an already established exception. However, if the IRS or Congress were to defer the definition of preventive care to established national standards such as the USPSTF, they would resolve this issue as well as others.

### *C. The IRS Should Interpret HSA Law Addressing Eligibility and the Underlying Health Plan Conservatively, Not Liberally.*

Even though the premiums for HDHPs are low—on average—when compared to traditional health plans, the deductible requirements might nevertheless make the plans appear disadvantageous.[256] However, the potential for individuals covered by HDHPs to spend at least $1,200 each year on non-preventive medical care is ameliorated to an extent by Code section 223's guarantee to limit the insured's total annual expenses to the statutory out-of-pocket maximum.[257]

While Code section 223 seems to include all of the insured's expenses for covered benefits in the out-of-pocket maximum (with the exception of

253. *Health Care Company*, *supra* note 219.

254. *AMA Comments on Guidance*, *supra* note 219 ("Limiting the types of benefits that may be covered prior to meeting the deductible (1) preserves HSA incentives for patients to utilize health care services in a cost-conscious manner; (2) keeps premium costs down, thereby making HSAs affordable to more individuals; and (3) averts an invitation for States to mandate first-dollar coverage of the specified benefits.").

255. I.R.S. Notice 2004-50, 2004-2 C.B. 196, 201(Q&A 26).

256. Am. Health Ins. Plans, *supra* note 117.

257. I.R.C. § 223(c)(2)(A)(ii) (CCH 2009).

the plan's premium),[258] IRS guidance has taken a different approach. Since the codification of section 223, the IRS has permitted exceptions to the out-of-pocket maximum that undermine its purpose and ironically encourage insurers to impose benefit-specific limitations and separate benefit-specific deductibles. For example, the IRS permits HDHPs to have annual or lifetime limits on specific benefits.[259] The amounts paid by the insured that are above the limits are exempt from the out-of-pocket maximum as long as "significant other benefits remain available under the plan in addition to the benefits subject to the restriction or exclusion."[260] Additionally, an HDHP can have a "separate or higher deductible for specific benefits."[261] The amounts that the insured pays toward the separate or higher deductible are not out-of-pocket expenses, according to the most recent guidance, as long as significant other benefits are available under the HDHP in addition to the benefits that are subject to the separate or higher deductible.[262]

These rules leave the door open to abuse by insurers and employers who design HDHPs. While the IRS appears to attempt to discourage such abuse by requiring that the HDHP have "significant" benefits in addition to the restricted benefits, there is little guidance as to what combination of benefits qualify as "significant." At best, the guidance goes as far as to explain that a plan that only covers hospitalization or in-patient care does not provide significant benefits.[263] Consequently, the line between a plan that provides significant benefits and one that does not is unclear. Especially problematic are plan designs that take advantage of both exceptions by limiting some benefits while imposing separate deductibles for other benefits.

Moreover, recent guidance creates a rule that is starkly in contrast to Code section 223 and prior IRS guidance: Notice 2008-59 permits an eligible individual to have a health plan that is not an HDHP "as long as the deductible of the other coverage equals or exceeds the statutory minimum HDHP deductible."[264] This means that the out-of-pocket requirements for HDHPs do not apply to the "other coverage." Furthermore, the "other coverage" is not bound by the HDHP's requirement to subject all non-preventive expenses to the plan's deductible. However, the IRS's former position was that

258. *Id.* ("the sum of the annual deductible and the other annual out-of-pocket expenses required to be paid under the plan (other than for premiums) for covered benefits does not exceed—(I) $5,000 for self-only coverage, and (II) twice the dollar amount in subclause (I) for family coverage.").

259. I.R.S. Notice 2004-50, 2004-2 C.B. 196, 199 (Q&A 15).

260. *Id.*

261. I.R.S. Notice 2008-59, 2008-29 I.R.B. 123, 127 (Q&A 13).

262. *Id.*

263. *Id.* at (Q&A 14).

264. *Id.* at (Q&A 7).

"eligible individuals for HSAs are individuals who are covered by a high deductible health plan and no other health plan that is not a high deductible health plan."[265] The farthest that the IRS had diverged from this rule, prior to Notice 2008-59, was its guidance allowing eligible individuals to enroll in coverage that postpones benefits until the insured pays her HDHP deductible.[266]

For example, in Revenue Ruling 2004-38, the IRS refused stand-alone drug plans unless, similar to the post-deductible HRA, the drug plan "does not provide benefits until the minimum annual deductible of the HDHP has been satisfied."[267] However, the new guidance does not require that the "other coverage" suspend the provision of benefits until the eligible individual has satisfied her annual HDHP deductible. Read literally, the new guidance permits an eligible individual to enroll in a separate plan with a high deductible that provides first dollar coverage for select benefits, such as chronic illness and disease medications. The cost of such a position is high: anyone can evade the stringent HDHP requirements by enrolling in creatively designed health plans that circumvent the deductible requirements. Accordingly, the IRS should amend Notice 2008-59 to clarify that an eligible individual may have other coverage only if the benefits covered by the other coverage are suspended until the eligible individual has satisfied her deductible under an HSA-compatible HDHP.

In combination, the above rules begin to transform HDHPs into traditional health plans and soften the eligibility requirements for HSAs. Furthermore, these rules complicate HSAs rather than simplify them by straying from the clear boundaries provided by Code section 223(c)(2). The IRS should adopt a more conservative approach. Notice 2008-59 should be modified so that deductible and out-of-pocket requirements conform to the simple rules established under Code section 223.

## CONCLUSION

Health Savings Accounts have vast potential. The tax-advantaged HSA offers individuals the opportunity to save for their families' future medical expenses. Additionally, HDHPs offer a less expensive alternative to traditional health plans, a notable advantage that is becoming increasingly apparent as the cost of health care grows more expensive with each passing year. Therefore, it is not surprising that the HSA has been well-received during its

265. Rev. Rul. 2004-38, 2004-1 C.B. 717.
266. *E.g.*, *Id.*
267. *Id.*

initial six years in the marketplace. Yet, whether HSAs will continue to experience prolonged growth is in part dependent upon making the accounts and their accompanying health plans attractive to those who are not yet sold on their value. Achieving this result requires resolution of the problems that currently weaken the HSA.

Namely, Congress should repeal the qualified distribution and permit employees to establish HSAs while temporarily keeping their current arrangements. Additionally, Congress or the IRS should modify the definition of preventive care to defer to the Department of Health and Human Service's Preventive Task Force or to other nationally recognized guidelines. Moreover, the IRS and Congress should decline recent invitations to expand the definition of preventive care to include medications that treat chronic disease. Instead, the IRS should narrow the scope of preventive care to those services and procedures that prevent the onset of chronic disease and promote healthy lifestyle choices. Finally, the IRS should adopt a conservative approach to interpreting HSA law that addresses the underlying health plan design and eligibility; recent guidance has the effect of reducing the HDHP to traditional coverage. These modifications would both strengthen and simplify HSAs and increase their appeal to consumers at a time when American health care needs the HSA the most.